Date : ...../...../.....
Jour Mois Année

Madame, Monsieur,

Vous allez voir en consultation un médecin.

Avant de débuter la consultation, nous vous remercions de bien vouloir remplir le questionnaire ci-dessous, en cochant la case correspondant à votre état. Vous pouvez être aidé par la personne qui vous accompagne.

1	**Avez-vous perdu involontairement du poids au cours de la dernière année ?**	☐Oui ☐Non
	Si oui, précisez si la perte de poids a été de plus de 3 kilos ?	☐Oui ☐Non
2	**Combien de médicaments différents prenez-vous par jour ?**	__ __
3	**Avez-vous des problèmes de vue ?**	☐Oui ☐Non
4	**Avez-vous des problèmes d'audition ?**	☐Oui ☐Non
5	**Votre entourage vous a-t-il fait remarquer que vous aviez des problèmes de mémoire ?**	☐Oui ☐Non
6	**Recevez-vous de l'aide pour accomplir les actes de vie de tous les jours ?**	☐Oui ☐Non
	Si oui, précisez s'il s'agit d'un : ☐Parent et/ou ☐Ami et/ou ☐Professionnel	
	Avez-vous besoin d'aide pour…	
7	**… faire votre toilette ?**	☐Oui ☐Non
8	**… vos soins d'apparence corporelle ?**	☐Oui ☐Non
9	**… vous habiller ?**	☐Oui ☐Non
10	**… vous déplacer** (canne ou autre) **?**	☐Oui ☐Non
11	**… manger ?**	☐Oui ☐Non
12	**… utiliser le téléphone ?**	☐Oui ☐Non
13	**… prendre les transports en commun ?**	☐Oui ☐Non
14	**… prendre vos médicaments ?**	☐Oui ☐Non
15	**… gérer votre argent ?**	☐Oui ☐Non
16	**Perdez-vous vos urines et/ou selles ?**	☐Oui ☐Non
17	**Vous sentez-vous aujourd'hui :** ☐ **Heureux** ☐ **Malheureux** ☐ **Ni l'un ni l'autre**	
18	**Vous sentez-vous plein d'énergie ?**	☐Oui ☐Non
19	**Avez-vous pratiqué une activité physique** (marche, jardinage, vélo, etc…) **au moins pendant 1 heure par semaine au cours du dernier mois ?**	☐Oui ☐Non
20	**Avez-vous fait au moins une chute au cours des 12 derniers mois ?**	☐Oui ☐Non

Avez-vous rempli seul ce questionnaire ? ☐ Oui ☐ Non
Si vous avez coché non, qui vous a aidé ?
☐ Conjoint ☐ Membre famille ☐ Ami ☐ Autre : .....

Date : ..... /...../.....
Year Month Day

Madam, Mister,

You will be seen in consultation by a physician.

Before starting the consultation, would you please complete this short questionnaire by filling in the appropriate box the way you perceive your own health. The person accompanying you may help you.

1	**Have you involuntary lost weight in the past year?**	☐Yes ☐No
	If yes, was the lost of weight above 3 kg?	☐Yes ☐No
2	**How many different drugs do you take daily?**	__ __
3	**Do you have sight problems?**	☐Yes ☐No
4	**Do you have hearing problems?**	☐Yes ☐No
5	**Has someone around you noticed that you have memory problems?**	☐Yes ☐No
6	**Do you receive home-help services?**	☐Yes ☐No
	If yes, from whom? : ☐Family and/or ☐Friend and/or ☐Professional	
Do you need help for…		
7	**… toileting?**	☐Yes ☐No
8	**… bathing?**	☐Yes ☐No
9	**… dressing?**	☐Yes ☐No
10	**… walking and/or transfering?**	☐Yes ☐No
11	**… feeding?**	☐Yes ☐No
12	**… phoning?**	☐Yes ☐No
13	**… take public transports?**	☐Yes ☐No
14	**… managing your medications on your own?**	☐Yes ☐No
15	**… handle your finances on your own?**	☐Yes ☐No
16	**Are you incontinent (urine and/or stool)?**	☐Yes ☐No
17	**How do you feel today? ☐ Happy ☐ Unhappy ☐ Neither one nor the other**	
18	**Do you feel energetic?**	☐Yes ☐No
19	**Did you do regular physical activities** (walking, bicycle, etc…), **at least one hour per week in the past month?**	☐Yes ☐No
20	**Did you fall in the previous year** (at least one fall)**?**	☐Yes ☐No

Have you received help to complete the questionnaire? ☐ Yes ☐ No
If yes who helped you?
☐ Spouse ☐ Family member ☐ Friend ☐ Other: .....

FRAILTY SCORING

Modified Frailty Index
Comprehensive Geriatric Assessment (FI-CGA) score:

DOMAINS	Scoring			Score	Test to do if score > 0
	0	1	2		
Nutrition	Item 1: No	-	Item 1: Yes		MNA
Multimorbidity	Item 2: <5	Item 2: 5-8	Item 2: >8		
Communication	Item 3: No AND Item 4: No	Item 3 OR 4: Yes	Item 3 AND 4: Yes		
Cognition	Item 5: No	-	Item 5: Yes		S-MMSE
ADL	Items 7 to 11: ≥4 No	Items 7 to 11: 2-3 No	Items 7 to 11: ≤1 No		
IADL	Items 12 to 15: 4 No	Items 12 to 15: 3 No	Items 12 to 15: ≤2 No		
Continence	Item 16: No	-	Item 16: Yes		
Mood	Item 17: Happy AND Item 18: Yes	Item 17: Neither one nor the other AND Item 18: Yes	Item 17: Sad AND/OR Item 18: No		4-item GDS
Mobility	Item 19: Yes AND Item 20: No	Item 19: No AND Item 20: No	Item 20: Yes		Five times site to stand
	TOTAL SCORE			/18	

Frailty level (/18): .....

Score from 0 to 2 : **NO frailty / Vigorous individual**

Score from 3 to 7 : **MILD frailty**

Score from 8 to 12 : **MODERATE frailty**

Score >12 : **SEVERE frailty**

RECOMMENDATIONS

DOMAINS	RESPONSES	TEST SCORES	RECOMMENDATIONS
Nutrition	Item 1: Yes	MNA score ≤11	– Eliminate worst evolution of acute and/or chronic disease – Prescribe oral vitamin D supplementation if hypovitaminosis D – Request dietician consultation
Home help services ADL IADL	Item 6: Yes Items 7 to 11: <5 Items 12 to 15: <4		– Reassess help if moderate frailty status or change in frailty status compared to previous consultation
Multimorbidity	Items 2: ≥5		– Reevaluation of medication
Communication	Item 3 OR Item 4: yes		– Assess glasses and/or hearing aids (appropriate or not)
Cognition	Item 5: Yes	S-MMSE score≤4	– MMSE and/or Memory consultation
Mood	Item 17: Sad AND/OR Item 18: No	4-item GDS score≥1	– Suspicion of depression: psychiatric consultation and/or anti-depressant
Mobility	Item 20: Yes OR FTSS ≥15 s		– Physiotherapist and/or occupational therapist assessment – Physical exercises – Prescribe oral vitamin D supplementation if hypovitaminosis D

Mini Nutritional Assessment (MNA)

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake ☐

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss ☐

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out ☐

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no ☐

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems ☐

F1 Body Mass Index (BMI) (weight in kg) / (height in m)^2 ☐
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater ☐

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater ☐

Screening score ☐☐
(max. 14 points)

12-14 points:	☐	Normal nutritional status
8-11 points:	☐	At risk of malnutrition
0-7 points:	☐	Malnourished

Save
Print
Reset

1 Short Mini Mental Status Eamination (S-MMSE)

Repeat the following three words after me:

Accordion	☐Check if correct
Mimosa	☐Check if correct
Elephant	☐Check if correct
Sub-score	**__ /3**
Distractive task:	
Spell the word "WORLD" backward	☐Check if correct
Subtract 7 from 100 and keep subtracting 7 from what's left until I tell you stop: ☐93 ☐86 ☐79 ☐72 ☐65	☐Check if correct
What were the 3 words that I asked you to remember?	
Accordion	☐Check if correct
Mimosa	☐Check if correct
Elephant	☐Check if correct
Sub-score	**__ /3**
TOTAL SCORE (abnormal if ≤4)	**__ /6**

2 Geriatric Depression Scale (GDS)

	1 point	0 point
Are you basically satisfied with life?	☐No	☐Yes
Do you feel that your life is empty?	☐Yes	☐No
Are you afraid that something bad is going to happen to you?	☐Yes	☐No
Do you feel happy most of the time?	☐No	☐Yes
TOTAL SCORE (abnormal if ≥1)	**__ /4**	

3 Five Time Sit-to-Stand test:

Ask the patient to Sit-to-Stand five times as quick as possible:

	Able ☐Yes ☐No (☐Hands helps)
If yes, TIME SCORE: (abnormal if ≥ 15 seconds)	_____ seconds