Label or
Name_____
DOB_____

GERIATRIC SCREENING TOOL

Current Height: ____ Height at age 40: ___ Weight: _____

PROBLEM	SCREENING MEASURE	POSITIVE SCREEN	COMMENTS
1. VISION	Ask the question: "Because of your eyesight, do you have trouble driving a car, watching television, reading or doing any of your daily activities?" *Or* test with the Snellen Eye chart.	"Yes" to question. Or, inability to read at better than 20/40 on the Snellen eye chart.	□ Positive □ Negative □ Ophthalmology Referral □ _____ □ Performed at another time, see progress note dated _____
2. HEARING	Ask the patient: "Have you ever been embarrassed about your hearing? Do you have trouble hearing whispers? Do you have trouble hearing at the movies, in theaters, or at religious functions? Does your hearing lead to arguments with your family? Do you have trouble hearing particular voices among all the 'hubbub' in restaurants?" *Or* administer the whispered *voice test* (Mulrow and Lictenstein, JGIM, vol 6, p.250 in the Geriatric Assessment P&P). *Or* use an audioscope set at 40dB. Test the patient's hearing using 1,000 and 2,000 Hz.	"Yes" to any question. Or, inability to repeat correctly 50% of whispered words. Or, inability to hear 1000 or 2000 Hz in both ears and inability to hear both frequencies in either ear.	□ Positive □ Negative □ ENT Referral □ Audiometry □ Hearing Aid □ _____ □ Performed at another time, see progress note dated _____
3. LEG MOBILITY	Time the patient after giving these directions: "Rise from the chair. Then walk 10 feet briskly, turn, walk back to the chair and sit down".	Unable to complete task in 15 seconds.	□ Positive □ Negative □ Fall Prevention Referral □ P.T. Consult □ Assistive Device □ _____ □ Performed at another time, see progress note dated _____
4. URINARY INCONTINENCE	Ask this question: "In the past year, have you ever lost control of your urine."	"Yes" to this question.	□ Positive □ Negative □ Schedule Pelvic Exam □ Urodynamic Studies □ Urology Referral □ _____ □ Performed at another time, see progress note dated _____
5. NUTRITION AND WEIGHT LOSS	Ask this question: " Have you lost 10 lbs. over the past six months without trying to do so?" AND review weights in the chart from the past 6 months.	"Yes" to the question or a weight loss of > 5%.	□ Positive □ Negative □ Social Work Referral □ Dietary Consult □ _____ □ Performed at another time, see progress note dated _____

PROBLEM	SCREENING MEASURE	POSITIVE SCREEN	COMMENTS
6. MEMORY	Three item recall. Or, the Folstein's Mini-Mental Exam`.	Unable to remember all three items after one minute or a score of less than 25 on the MMSE.	□ Positive □ Negative □ Dementia Work-Up □ _____ □ Performed at another time, see progress note dated _____
7. DEPRESSION	Ask this question: "Do you often feel sad or depressed?"	"Yes" to the question, and/or meets DSM IV criteria.	□ Positive □ Negative □ Psych Referral □ _____ □ Performed at another time, see progress note dated _____
8. ACTIVITIES OF DAILY LIVING AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING	Ask the patient these six questions: 1. "Are you able to go shopping for groceries or clothes" 2. "Are you able to bathe—sponge bath, tub bath or shower?" 3. "Are you able to dress yourself: such as put on a shirt; button and zip your clothes; or put on your shoes?" 4. "Are you able to handle your own finances?" 5. "Are you able to make your own meals?" 6. "Are you able to climb the stairs in your home?"	If the patient answers no to any of these questions AND they do not have adequate help.	□ Positive □ Negative □ Social Work Referral □ _____ □ Performed at another time, see progress note dated _____
9. OTHER			

Performed by:

_____

Signature/Date

Reviewed by:

_____

Clinician Signature/Date