Senior Adult Supplement Screening Questionnaire (SAOP3)

1. Activities of Daily Living / Instrumental Activities of Daily Living (ADL/IADL):

	(please check one for each line)		
a. Do you use a cane or a walker?	[ ] Yes	[ ] Occasionally	[ ] No
b. Do you need help to get out of bed/chair?	[ ] Yes	[ ] Occasionally	[ ] No
c. Have you tripped or fallen in the past year?	[ ] Yes		[ ] No
d. Do you have problems holding your urine or stools *(more than small leaks controlled with a pad)?*	[ ] Yes	[ ] Occasionally	[ ] No
e. Can you dress yourself completely?	[ ] Yes	[ ] Yes, but with help	[ ] No
f. Can you feed yourself?	[ ] Yes	[ ] Yes, but with help	[ ] No
g. Are you able to drive?	[ ] Yes	[ ] Have never driven	[ ] No
h. Are you able to prepare your own meals?	[ ] Yes	[ ] Yes, but with help	[ ] No
i. Are you able to go shopping?	[ ] Yes	[ ] Yes, but with help	[ ] No
j. Can you take care of your finances?	[ ] Yes	[ ] Yes, but with help	[ ] No
k. Can you use a telephone?	[ ] Yes	[ ] Yes, but with help	[ ] No
l. Do you remember to take your medicines?	[ ] Yes	[ ] Yes, but with help	[ ] No
m. Can you shower or bathe yourself completely?	[ ] Yes	[ ] Yes, but with help	[ ] No

2. Have you lost 5 or more pounds in the past 6 months *<u>without dieting</u>*?	[ ] Yes [ ] No
3. Has your appetite decreased in the last 3 months?	[ ] Yes [ ] No
4. Has there been a change in the *types* of foods you are able to eat?	[ ] Yes [ ] No
5. Are you able to pay for your prescription medications?	[ ] Yes [ ] No
6. Do you feel you are sleeping well?	[ ] Yes [ ] No
7. If it was necessary, is there someone who could help take care of you, if needed?	[ ] Yes [ ] No
8. Do you feel sad more days than not?	[ ] Yes [ ] No
9. Have you lost interest in things you used to enjoy (hobbies, food, sex, being with friends/family)?	[ ] Yes [ ] No
10. On a scale of 1 to 10, rate your present quality of life (10 is the best life, 1 is the worst). [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10	
11. On a scale of 1 to 10, rate your present overall health (10 is the best health, 1 is the worst). [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10	

Signature of Healthcare Professional_____ **Time:**_____ **Date:** _____

PATIENT NAME:

_____

DATE OF BIRTH: _____

MR#: _____

Senior Adult Supplement Screening Questionnaire (SAOP3)

The Mini-Cog Evaluation ™

Instructions for the Mini-Cog

Step 1 : Three Word Registration

Look directly at the patient and say, *"Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. Please say them for me now."* If the person cannot repeat them after 3 times, move on to Step 2.

Version 1	**Version 2**	**Version 3**	**Version 4**	**Version 5**	**Version 6**
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2 : Clock Drawing

Say "Next I want you to draw a clock for me. First put the numbers where they go." When that is completed "Now set the hands to 10 past 11."

Step 3 : Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say " What were the three words I asked you to remember?"

Patient's answers

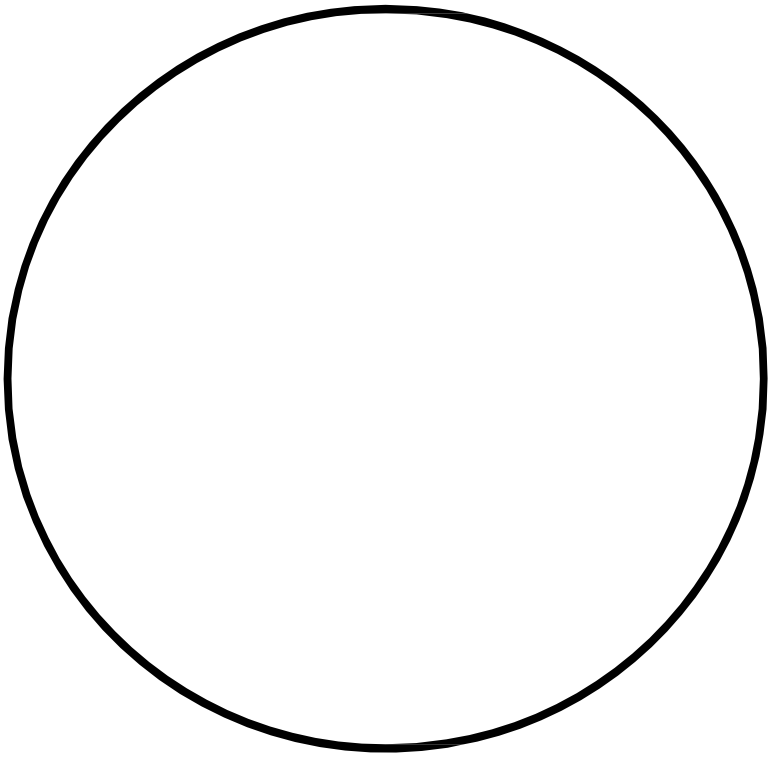
PATIENT NAME: _____

DATE OF BIRTH: _____

MR#: _____

Senior Adult Supplement Screening Questionnaire (SAOP3)

The Mini-Cog Evaluation ™



PATIENT NAME: _____

DATE OF BIRTH: _____

MR#: _____

Senior Adult Supplement Screening Questionnaire (SAOP3)

MINI COG SCORING
Number of correct items recalled:_____(if 3 correct **Normal**, if 1-2 correct see clock results, if 0 correct: **Abnormal**
If 1-2, is clock drawing abnormal? [ ] Yes (cognitive impairment) [ ] No (Normal)

ADL/IADL mobility items (1a-1d if at least *two* Yes responses) then consult *[If* **YES/Occasionally** to 1d,may administer the modified 3 Incontinence Questionnaire(3IQ)] □ *Outpatient Physical Therapy* □ *Current treatment* □ *Pt declined*
ADL/IADL items (1e-1m):): if more than one is *not* **YES** responses, then consult *Outpatient Occupational Therapy* Refer to □ *PT* □ *OT* □ *Current treatment* □ *Pt declined*
Nutrition items (2-4): if at least two **Yes** responses, then consult □ *Outpatient Nutrition* □ *Current treatment* □ *Pt declined*
Psychosocial items (7-9): if response is **No** to 1 and/or **Yes** to 2 or 3, then offer □ *Behavioral Medicine* □ *Social Work* □ *Pt declined*
Quality of Life (QOL) and self-rated health items (10-11): if score less than 8, then consult □ *Social Work* □ *Behavioral Medicine* □ *Pt declined*
Mini-Cog: + for cognitive impairment consult □ *Outpatient Occupational Therapy* □ *Speech Lang Path* □ *Neurology* □ *Pt declined*
Number of medications greater than 5, then consult □ *Pharmacy* □ *Pt declined*
If **No** to # 5, refer to □ *Social Work/and or* □ *Patient Financial Services* □ *Pt declined*
If **No** to # 6 administer Pittsburg Sleep Quality Index (PSQI) for further referral

Signature of Healthcare Professional_____**Time:**_____**Date:** _____

Printed name of Healthcare Professional:_____**Pager number:** _____

PATIENT NAME:
_____
DATE OF BIRTH: _____
MR#: _____