

Decision Making Capacity Assessment Program

Spring 2026 – Class 3

June 3, 2026

Examples of forms for testing/assessment tools discussed in class

**NOTE: The following pages are NOT to be used
for clinical testing or assessment.**

These images are provided for you to see the format,
which will also be discussed in class.

Some of these tools are copyright protected and/or
only available for use under licensure. Also, tools
may be updated and you should use the most current
version. Therefore, each page is marked “example”
and the link to the online resource is provided.

Refer to the “Tools Links” handout for information and
resources on these and other tests/tools.

The Mini-Mental State Exam

Patient _____ Examiner _____ Date _____

Maximum Score

5 ()

5 ()

Orientation

What is the (year) (season) (date) (day) (month)?

Where are we (state) (country) (town) (hospital) (floor)?

Registration

3 ()

Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record.

Trials _____

Attention and Calculation

5 ()

Serial 7's. 1 point for each correct answer. Stop after 5 answers.

Alternatively spell "world" backward.

Recall

3 ()

Ask for the 3 objects repeated above. Give 1 point for each correct answer.

Language

2 ()

Name a pencil and watch.

1 ()

Repeat the following "No ifs, ands, or buts"

3 ()

Follow a 3-stage command:

"Take a paper in your hand, fold it in half, and put it on the floor."

1 ()

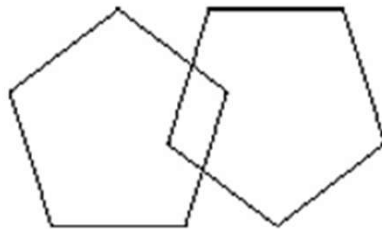
Read and obey the following: CLOSE YOUR EYES

1 ()

Write a sentence.

1 ()

Copy the design shown.



Total Score

ASSESS level of consciousness along a continuum _____

Alert Drowsy Stupor Coma

"MINI-MENTAL STATE." A PRACTICAL METHOD FOR GRADING THE COGNITIVE STATE OF PATIENTS FOR THE CLINICIAN. *Journal of Psychiatric Research*, 12(3): 189-198, 1975. Used by permission.

Figure 3-6: Blessed Orientation-Memory-Concentration Test (BOMC)

The Blessed Orientation-Memory-Concentration Test (BOMC) is an extremely condensed form (consisting of only six simple verbal questions) of a larger 26-question instrument, the Information-Memory-Concentration Mental Status Test (IMCMST) devised by Blessed and colleagues. On the BOMC the items range from easy to difficult, in order of increasing difficulty: time of day, count 20 to one backwards, month, year, months backward, and memory phrase. As with the MMSE, this tool is sometimes used as an initial screen to alert clinicians to the possibility of cognitive impairment and to monitor this condition. It is provider-administered and usually takes less than five minutes to complete. Like MMSE, it is a sensitive indicator of cognitive impairment but not diagnosis-specific for delirium or dementia.

ITEMS		MAXIMUM ERROR	SCORE		WEIGHT		
1	What <i>year</i> is it now?	1	_____	x	4	=	_____
2	What <i>month</i> is it now?	1	_____	x	3	=	_____
Memory phrase	Repeat this phrase after me: John Brown, 42 Market Street, Chicago						
3	About what <i>time</i> is it?	1	_____	x	3	=	_____
4	<i>Count</i> backwards 20 to 1	2	_____	x	2	=	_____
5	Say the months in reverse order	2	_____	x	2	=	_____
6	Repeat the memory phrase	5	_____	x	2	=	_____

Score of 1 for each incorrect response; maximum weighted error score = 28.

A score above 10 is rated as abnormal.

Source: *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision. Washington DC: American Psychiatric Association, 2000. Copyright 2000, American Psychiatric Association. Reproduced with permission.

GPCOG Screening Test

Step 1: Patient Examination

Unless specified, each question should only be asked once

Name and Address for subsequent recall test

1. "I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington." (Allow a maximum of 4 attempts).

Time Orientation

Correct Incorrect

2. What is the date? (exact only)

☐
☐

Clock Drawing – use blank page

3. Please mark in all the numbers to indicate the hours of a clock (correct spacing required)
4. Please mark in hands to show 10 minutes past eleven o'clock (11.10)

☐
☐
☐
☐

Information

5. Can you tell me something that happened in the news recently? (Recently = in the last week. If a general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).

☐
☐

Recall

6. What was the name and address I asked you to remember

John

Brown

42

West (St)

Kensington

☐
☐
☐
☐
☐
☐
☐
☐
☐
☐

(To get a total score, add the number of items answered correctly)

Total correct (score out of 9)

/9

If patient scores 9, no significant cognitive impairment and further testing not necessary.

If patient scores 5-8, more information required. Proceed with Step 2, informant section.

If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

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Informant Interview

Date: _____

Informant's name: _____

Informant's relationship to patient, i.e. informant is the patient's: _____

These six questions ask how the patient is compared to when s/he was well, say 5 – 10 years ago

Compared to a few years ago:

- | | Yes | No | Don't Know | N/A |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| ▪ Does the patient have more trouble remembering things that have happened recently than s/he used to? | ☐ | ☐ | ☐ | |
| ▪ Does he or she have more trouble recalling conversations a few days later? | ☐ | ☐ | ☐ | |
| ▪ When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often? | ☐ | ☐ | ☐ | |
| ▪ Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)? | ☐ | ☐ | ☐ | ☐ |
| ▪ Is the patient less able to manage his or her medication independently? | ☐ | ☐ | ☐ | ☐ |
| ▪ Does the patient need more assistance with transport (either private or public)?
(If the patient has difficulties due only to physical problems, e.g. bad leg, tick 'no') | ☐ | ☐ | ☐ | ☐ |

(To get a total score, add the number of items answered 'no', 'don't know' or 'N/A')

Total score (out of 6)

If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.

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The Mini Cog™

Administration:

1. Instruct the patient to listen carefully to and remember 3 unrelated words and then to repeat the words. The same 3 words may be repeated to the patient up to 3 tries to register all 3 words.
2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time. The time 11:10 has demonstrated increased sensitivity.
3. Ask the patient to repeat the 3 previously stated words.

Scoring: (Out of a total of 5 points)

Give 1 point for each recalled word after the CDT distractor. Recall is scored 0-3.

The CDT distractor is scored 2 if normal and 0 if abnormal.

(Note: The CDT is considered normal if all numbers are present in the correct sequence and position, and the hands readably display the requested time. Length of hands is not considered in the score.)

Interpretation of Results:

0-2: Positive screen for dementia

3-5: Negative screen for dementia

Sources:

Borson, S., Scanlan, J., Brush, M., Vitallano, P., & Dokmak, A. (2000). The Mini-Cog: A cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. *International Journal of Geriatric Psychiatry*, 15(11), 1021-1027.

Borson, S., Scanlan, J.M., Watanabe, J., Tu, S.P., & Lessig, M. (2006). Improving identification of cognitive impairment in primary care. *International Journal of Geriatric Psychiatry*, 21(4), 349-355.

Lessig, M., Scanlan, J., Nazemi, H., & Borson, S. (2008). Time that tells: Critical clock-drawing errors for dementia screening. *International Psychogeriatrics*, 20(3), 459-470.



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<http://geriatrics.stanford.edu>

THE SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

CLICK TO RESET THE FORM

QUESTION	RESPONSE	INCORRECT RESPONSES
1. What are the date, month, and year?		
2. What is the day of the week?		
3. What is the name of this place?		
4. What is your phone number?		
5. How old are you?		
6. When were you born?		
7. Who is the current president?		
8. Who was the president before him?		
9. What was your mother's maiden name?		
10. Can you count backward from 20 by 3's?		

SCORING:*

0–2 errors: normal mental functioning

5–7 errors: moderate cognitive impairment

3–4 errors: mild cognitive impairment

8 or more errors: severe cognitive impairment

*One more error is allowed in the scoring if a patient has had a grade school education or less. One less error is allowed if the patient has had education beyond the high school level.

Source: Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of American Geriatrics Society*. 23, 433-41.

AD8 Dementia Screening Interview

Patient ID#: _____

CS ID#: _____

Date: _____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, *Neurology* 2005;65:559-564

Copyright 2005. The AD8 is a copyrighted instrument of the Alzheimer's Disease Research Center, Washington University, St. Louis, Missouri.

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Example for class use only – not for clinical usage. Refer to original source for current form to use.

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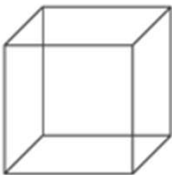
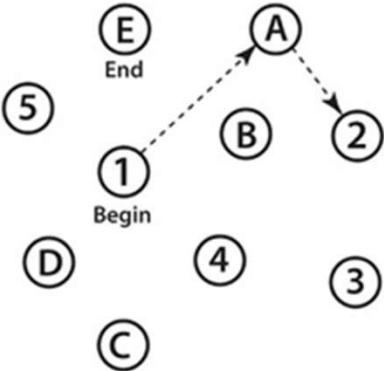
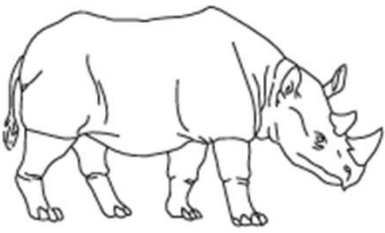
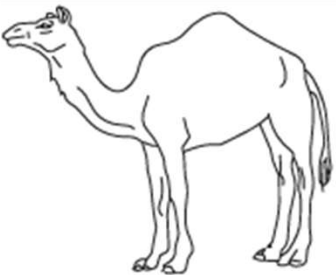
QUICK DEMENTIA RATING SYSTEM (QDRS)

The following descriptions characterize changes in the patient's cognitive and functional abilities. You are asked to compare the patient now to how they used to be – the key feature is **change**. Choose **one answer** for each category that best fits the patient – **NOTE**, not all descriptions need to be present to choose an answer

1. MEMORY AND RECALL	
0	No obvious memory loss or inconsistent forgetfulness that does not interfere with function in everyday activities
0.5	Consistent mild forgetfulness or partial recollection of events that may interfere with performing everyday activities; repeats questions/statements, misplaces items, forgets appointments
1	Mild to moderate memory loss; more noticeable for recent events; interferes with performing everyday activities
2	Moderate to severe memory loss; only highly learned information remembered; new information rapidly forgotten
3	Severe memory loss, almost impossible to recall new information; long-term memory may be affected
2. ORIENTATION	
0	Fully oriented to person, place, and time nearly all the time
0.5	Slight difficulty keeping track of time; may forget day or date more frequently than in the past
1	Mild to moderate difficulty keeping track of time and sequence of events; forgets month or year; oriented to familiar places but gets confused outside of familiar areas; gets lost or wanders
2	Moderate to severe difficulty, usually disoriented to time and place (familiar and unfamiliar); frequently dwells in past
3	Only oriented to their name, although may recognize family members
3. DECISION MAKING AND PROBLEM SOLVING ABILITIES	
0	Solves everyday problems without difficulty; handles personal business and financial matters well; decision-making abilities consistent with past performance
0.5	Slight impairment or takes longer to solve problems; trouble with abstract concepts; decisions still sound
1	Moderate difficulty with handling problems and making decisions; defers many decisions to others; social judgment and behavior may be slightly impaired; loss of insight
2	Severely impaired in handling problems, making only simple personal decisions; social judgment and behavior often impaired; lacks insight
3	Unable to make decisions or solve problems; others make nearly all decisions for patient
4. ACTIVITIES OUTSIDE THE HOME	
0	Independent in function at usual level of performance in profession, shopping, community and religious activities, volunteering, or social groups
0.5	Slight impairment in these activities compared to previous performance; slight change in driving skills; still able to handle emergency situations
1	Unable to function independently but still may attend and be engaged; appears "normal" to others; notable changes in driving skills; concern about ability to handle emergency situations
2	No pretense of independent function outside the home; appears well enough to be taken to activities outside the family home but generally needs to be accompanied
3	No independent function or activities; appear too ill to be taken to activities outside the home
5. FUNCTION AT HOME AND HOBBY ACTIVITIES	
0	Chores at home, hobbies and personal interests are well maintained compared to past performance
0.5	Slight impairment or less interest in these activities; trouble operating appliances (particularly new purchases)
1	Mild but definite impairment in home and hobby function; more difficult chores or tasks abandoned; more complicated hobbies and interests given up
2	Only simple chores preserved, very restricted interest in hobbies which are poorly maintained
3	No meaningful function in household chores or with prior hobbies

6. TOILETING AND PERSONAL HYGIENE	
0	Fully capable of self-care (dressing, grooming, washing, bathing, toileting)
0.5	Slight changes in abilities and attention to these activities
1	Needs prompting to complete these activities but may still complete independently
2	Requires some assistance in dressing, hygiene, keeping of personal items; occasionally incontinent
3	Requires significant help with personal care and hygiene; frequent incontinence
7. BEHAVIOR AND PERSONALITY CHANGES	
0	Socially appropriate behavior in public and private; no changes in personality
0.5	Questionable or very mild changes in behavior, personality, emotional control, appropriateness of choices
1	Mild changes in behavior or personality
2	Moderate behavior or personality changes, affects interactions with others; may be avoided by friends, neighbors, or distant relatives
3	Severe behavior or personality changes; making interactions with others often unpleasant or avoided
8. LANGUAGE AND COMMUNICATION ABILITIES	
0	No language difficulty or occasional word searching; reads and writes as well as in past
0.5	Consistent mild word finding difficulties, using descriptive terms or takes longer to get point across, mild problems with comprehension, decreased conversation; may affect reading and writing
1	Moderate word finding difficulty in speech, cannot name objects, marked reduction in word production; reduced comprehension, conversation, writing and/or reading
2	Moderate to severe impairments in speech production or comprehension; has difficulty communicating thoughts to others; limited ability to read or write
3	Severe deficits in language and communication; little to no understandable speech is produced
9. MOOD	
0	No changes in mood, interest or motivation level
0.5	Occasional sadness, depression, anxiety, nervousness or loss of interest/motivation
1	Daily mild issues with sadness, depression, anxiety, nervousness or loss of interest/motivation
2	Moderate issues with sadness, depression, anxiety, nervousness or loss of interest/motivation
3	Severe issues with sadness, depression, anxiety, nervousness or loss of interest/motivation
10. ATTENTION AND CONCENTRATION	
0	Normal attention, concentration and interaction with his/her environment and surroundings
0.5	Mild problems with attention, concentration, and interaction with environment and surroundings, may appear drowsy during day
1	Moderate problems with attention and concentration, may have staring spells or spend time with eyes closed, increased daytime sleepiness
2	Significant portion of the day is spent sleeping, not paying attention to environment, when having a conversation may say things that are illogical or not consistent with topic
3	Limited to no ability to pay attention to external environment or surroundings
COGNITIVE SUBTOTAL (QUESTIONS 1, 2, 3, 8)	
BEHAVIORAL SUBTOTAL (QUESTIONS 4, 5, 6, 7, 9, 10)	
TOTAL QDRS SCORE	

Copyright 2013 *The Quick Dementia Rating System* James E. Galvin and New York University Langone Medical Center

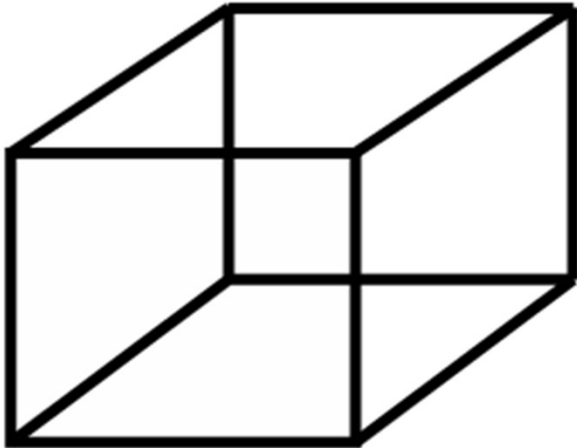
MONTREAL COGNITIVE ASSESSMENT (MOCA®) Version 8.1 English								Name: _____ Education: _____ Sex: _____		Date of birth: _____ DATE: _____																																
VISUOSPATIAL / EXECUTIVE								 Copy cube		Draw CLOCK (Ten past eleven) (3 points)		POINTS																														
								☐ ☐ ☐		☐ ☐ ☐		___/5																														
NAMING													___/3																													
MEMORY								Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td>FACE</td> <td>VELVET</td> <td>CHURCH</td> <td>DAISY</td> <td>RED</td> </tr> <tr> <td>1ST TRIAL</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2ND TRIAL</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			FACE	VELVET	CHURCH	DAISY	RED	1 ST TRIAL						2 ND TRIAL						NO POINTS												
	FACE	VELVET	CHURCH	DAISY	RED																																					
1 ST TRIAL																																										
2 ND TRIAL																																										
ATTENTION								Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order.		☐ 2 1 8 5 4		___/2																														
								Subject has to repeat them in the backward order.		☐ 7 4 2		___/1																														
Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors								☐ F B A C M N A A J K L B A F A K D E A A A J A M O F A A B		___/3																																
Serial 7 subtraction starting at 100.								☐ 93 ☐ 86 ☐ 79 ☐ 72 ☐ 65		___/3																																
								4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0																																		
LANGUAGE								Repeat: I only know that John is the one to help today.		☐		___/2																														
								The cat always hid under the couch when dogs were in the room.		☐		___/1																														
Fluency: Name maximum number of words in one minute that begin with the letter F.								☐ _____ (N ≥ 11 words)		___/2																																
ABSTRACTION								Similarity between e.g. banana - orange = fruit		☐ train - bicycle ☐ watch - ruler		___/5																														
DELAYED RECALL								<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>(MIS)</td> <td>Has to recall words WITH NO CUE</td> <td>FACE</td> <td>VELVET</td> <td>CHURCH</td> <td>DAISY</td> <td>RED</td> <td rowspan="3">Points for UNCUE recall only</td> </tr> <tr> <td>X3</td> <td></td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>X2</td> <td>Category cue</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>X1</td> <td>Multiple choice cue</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>MIS = ___/15</td> </tr> </table>		(MIS)	Has to recall words WITH NO CUE	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUE recall only	X3		☐	☐	☐	☐	☐	X2	Category cue						X1	Multiple choice cue						MIS = ___/15			___/6
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© Z. Nasreddine MD www.mocatest.org								MIS: ___/15 (Normal ≥ 26/30) Add 1 point if ≤ 12 yr edu		TOTAL		___/30																														
Administered by: _____ Training and Certification are required to ensure accuracy																																										

R U D A S		
The Rowland Universal Dementia Assessment Scale: A Multicultural Cognitive Assessment Scale. (Storey, Rowland, Basic, Conforti & Dickson, 2004). International Psychogeriatrics, 16 (1), 13-31		
Date: ____/____/____ Patient Name: _____		
Item Memory 1. (Instructions) I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 mins. time I will ask you what it is that we have to buy. You must remember the list for me. Tea, Cooking Oil, Eggs, Soap Please repeat this list for me (ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of five times.) Visuospatial Orientation 2. I am going to ask you to identify/show me different parts of the body. (<i>Correct = 1</i>). Once the person correctly answers 5 parts of this question, do not continue as the maximum score is 5. (1) show me your right foot 1 (2) show me your left hand 1 (3) with your right hand touch your left shoulder 1 (4) with your left hand touch your right ear 1 (5) which is (indicate/point to) my left knee 1 (6) which is (indicate/point to) my right elbow 1 (7) with your right hand indicate/point to my left eye 1 (8) with your left hand indicate/point to my left foot 1 5 Praxis 3. I am going to show you an action/exercise with my hands. I want you to watch me and copy what I do. Copy me when I do this ... (One hand in fist, the other palm down on table - alternate simultaneously.) Now do it with me: Now I would like you to keep doing this action at this pace until I tell you to stop - approximately 10 seconds. (Demonstrate at moderate walking pace). Score as: <i>Normal</i> = 2 (<i>very few if any errors; self-corrected, progressively better; good maintenance; only very slight lack of synchrony between hands</i>) <i>Partially Adequate</i> = 1 (<i>noticeable errors with some attempt to self-correct; some attempt at maintenance; poor synchrony</i>) <i>Failed</i> = 0 (<i>cannot do the task; no maintenance; no attempt whatsoever</i>) 2 Visuoconstructional Drawing 4. Please draw this picture exactly as it looks to you (Show cube on back of page). (<i>Yes = 1</i>) Score as: (1) Has person drawn a picture based on a square? 1 (2) Do all internal lines appear in person's drawing? 1  (3) Do all external lines appear in person's drawing? 1  3 Judgment 5. You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the road safely. (If person gives incomplete response that does not address both parts of answer, use prompt: "Is there anything else you would do?") Record exactly what patient says and circle all parts of response which were prompted. Score as: Did person indicate that they would look for traffic? (<i>YES = 2; YES PROMPTED = 1; NO = 0</i>) 2 Did person make any additional safety proposals? (<i>YES = 2; YES PROMPTED = 1; NO = 0</i>) 2 4	Max Score	

Example for class use only – not for clinical usage. Refer to original source for current form to use.

Example for class use only – not for clinical usage. Refer to original source for current form to use.

Memory Recall 1. (Recall) We have just arrived at the shop. Can you remember the list of groceries we need to buy? (Prompt: If person cannot recall any of the list, say "The first one was 'tea'." (Score 2 points each for any item recalled which was not prompted – use only 'tea' as a prompt.) Tea 2 Cooking Oil 2 Eggs 2 Soap 2 8 Language 6. I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute. (Repeat instructions if necessary). Maximum score for this item is 8. If person names 8 new animals in less than one minute there is no need to continue. <table><tr><td>1.</td><td>5.</td></tr><tr><td>2.</td><td>6.</td></tr><tr><td>3.</td><td>7.</td></tr><tr><td>4.</td><td>8.</td></tr></table> 8	1.	5.	2.	6.	3.	7.	4.	8.		
1.	5.									
2.	6.									
3.	7.									
4.	8.									
TOTAL SCORE =		/30								



VAMC SLUMS EXAMINATION

Questions about this assessment tool? E-mail aging@slu.edu

Name _____ Age _____

Is the patient alert? _____ Level of education _____

1. What day of the week is it? 1
2. What is the year? 1
3. What state are we in? 1
4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car
5. You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20.
- 1 How much did you spend?
- 2 How much do you have left?
6. Please name as many animals as you can in one minute.
0 0-4 animals 1 5-9 animals 2 10-14 animals 3 15+ animals
7. What were the five objects I asked you to remember? 1 point for each one correct.
8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
0 87 1 648 1 8537
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
- 2 Hour markers okay
- 2 Time correct
- 1 10. Please place an X in the triangle.
- 1 Which of the above figures is largest?
11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
- Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
- 2 What was the female's name?
- 2 What work did she do?
- 2 When did she go back to work?
- 2 What state did she live in?

TOTAL SCORE

SCORING

HIGH SCHOOL EDUCATION

27-30
21-26
1-20

NORMAL
MILD NEUROCOGNITIVE DISORDER
DEMENTIA

LESS THAN HIGH SCHOOL EDUCATION

25-30
20-24
1-19

CLINICIAN'S SIGNATURE

DATE

TIME

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. *Am J Geriatr Psych* 14:900-10, 2006.

Frontal Assessment Battery (FAB) https://www.psychdb.com/cognitive-testing/fab		
Patient Name:	Administered by:	Date:

Instructions
The FAB is a brief cognitive and behavioural battery that can be used at the bedside to assess frontal lobe functions. The FAB has validity in distinguishing frontotemporal dementia from other types of dementias such as early-stage Alzheimer's. The total maximum score is 18, with higher scores indicating better performance.

Reference
Dubois, B., Slachevsky, A., Litvan, I., & Pillon, B. (2000). The FAB: a frontal assessment battery at bedside. *Neurology*, 55(11), 1621-1626.

1. Similarities (Conceptualization)

"In what way are they alike?": A banana and an orange (answer: fruits) A table and a chair (answer: furniture) A tulip, a rose, and a daisy (answer: flowers)	If the patient says, "they are not alike" (total failure) or "both have peels" (partial failure) help the patient with a prompt by saying: "both a banana and an orange are..." However, credit 0 points for the first item. Do not help the patient for the last two items after this.	☐ 3 correct (3 points) ☐ 2 correct (2 points) ☐ 1 correct (1 point) ☐ 0 correct (0 points)
--	--	---

2. Lexical Fluency

"Say as many words as you can beginning with the letter 'S,' any words except surnames or proper nouns." The time allowed is 60 seconds	If the patient gives no response during the first 5 seconds, say: "for instance, snake." If the patient pauses for 10 seconds, prompt them by saying: "any word beginning with the letter 'S.'" Word repetitions or variations (i.e. - "shoe," "shoemaker"), surnames, or proper nouns are <i>not</i> counted as correct responses.	☐ >9 words (3 points) ☐ 6 to 9 words (2 points) ☐ 3 to 5 words (1 point) ☐ <3 words (0 points)
--	--	---

3. Motor Series ("Luria's Test")

Tell the patient: "Look carefully at what I'm doing." The examiner, seated in front of the patient, performs alone 3 times using the left hand the series of Luria motions of "fist-edge-palm." Prompt the patient: "Now, with your right hand do the same series, first with me, then alone." The examiner performs the series 3 times in total with the patient Now tell the patient: "Now, do it on your own." Observe the patient's actions	FIST EDGE (Bird's Eye View) PALM (Bird's Eye View)	☐ Patient performs 6 correct consecutive series alone (3 points) ☐ Patient performs at least 3 correct consecutive series alone (2 points) ☐ Patient fails alone, but performs three correct consecutive series with the examiner (1 point) ☐ Patient cannot perform three correct consecutive series even with the examiner (0 points)
--	---	--

4. Conflicting Instructions	
Tell the patient: "Tap twice when I tap once." To be sure that the patient has understood the instructions, do a series of 3 trial runs first: 1-1-1 Tell the patient: "Tap once when I tap twice." To be sure that the patient has understood the instruction, do a series of 3 trial runs first: 2-2-2 The examiner now performs the actual following series: 1-1-2-1-2-2-2-1-1-2	☐ No error (3 points) ☐ 1 or 2 errors (2 points) ☐ >2 errors (1 point) ☐ Patient taps like the examiner at least 4 consecutive times (0 points)
5. Go-No Go	
Tell the patient: "Tap once when I tap once." To be sure that the patient has understood the instruction, do a series of 3 trial runs first: 1-1-1 Tell the patient: "Do not tap when I tap twice." To be sure that the patient has understood the instruction, do a series of 3 trial runs first: 2-2-2 The examiner now performs the actual following series: 1-1-2-1-2-2-2-1-1-2	☐ No error (3 points) ☐ 1 or 2 errors (2 points) ☐ >2 errors (1 point) ☐ Patient taps like the examiner at least 4 consecutive times (0 points)
6. Prehension Behaviour (Grasp Reflex)	
1. The examiner is seated in front of the patient. 2. Place the patient's hands palm up on his/her knees. 3. Without saying anything or looking at the patient, the examiner brings his/her hands close to the patient's hands and touches the palms of both the patient's hands, to see if he/she will spontaneously take them. 4. If the patient takes the hands, the examiner will try again after asking him/her: "Now, do not take my hands."	☐ Patient does not take the examiner's hands (3 points) ☐ Patient hesitates and asks what he/she has to do (2 points) ☐ Patient takes the hands without hesitation (1 point) ☐ Patient takes the examiner's hand even after he/she has been told not to do so (0 points)
Total Score /18	

Interpretation

For age and education normative values, visit: <https://www.psychdb.com/cognitive-testing/fab#norms>

Example for class use only – not for clinical usage. Refer to original source for current form to use.

Trail Making Test, Part B

Client Name: _____ Date: _____

Trail Making Test, Part A

Client Name: _____ Date: _____

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Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) NO supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) WITH supervision, direction, personal assistance or total care
BATHING POINTS: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS: _____	(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = _____ 6 = High (patient independent) 0 = Low (patient very dependent)

Slightly adapted from Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, 10(1), 20-30.

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The Hartford Institute for Geriatric Nursing recognizes Mary Shelkey, PhD, ARNP and Meredith Wallace Kazer, PhD, APRN, A/GNP-BC as the original authors of this issue.

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The Lawton Instrumental Activities of Daily Living Scale

A. Ability to Use Telephone

1. Operates telephone on own initiative; looks up and dials numbers 1
2. Dials a few well-known numbers.....1
3. Answers telephone, but does not dial.....1
4. Does not use telephone at all.....0

B. Shopping

1. Takes care of all shopping needs independently.....1
2. Shops independently for small purchases 0
3. Needs to be accompanied on any shopping trip.....0
4. Completely unable to shop.....0

C. Food Preparation

1. Plans, prepares, and serves adequate meals independently 1
2. Prepares adequate meals if supplied with ingredients 0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet 0
4. Needs to have meals prepared and served.....0

D. Housekeeping

1. Maintains house alone with occasion assistance (heavy work).....1
2. Performs light daily tasks such as dishwashing, bed making.....1
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness.....1
4. Needs help with all home maintenance tasks 1
5. Does not participate in any housekeeping tasks 0

E. Laundry

1. Does personal laundry completely 1
2. Launders small items, rinses socks, stockings, etc 1
3. All laundry must be done by others 0

F. Mode of Transportation

1. Travels independently on public transportation or drives own car 1
2. Arranges own travel via taxi, but does not otherwise use public transportation 1
3. Travels on public transportation when assisted or accompanied by another 1
4. Travel limited to taxi or automobile with assistance of another 0
5. Does not travel at all.....0

G. Responsibility for Own Medications

1. Is responsible for taking medication in correct dosages at correct time.....1
2. Takes responsibility if medication is prepared in advance in separate dosages.....0
3. Is not capable of dispensing own medication 0

H. Ability to Handle Finances

1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank); collects and keeps track of income 1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc 1
3. Incapable of handling money 0

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist*, 9(3), 179-186.

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The Hartford Institute for Geriatric Nursing recognizes Carla Graf as the original author of this issue.

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Screening Tool: Cornell Scale for Depression in Dementia (CSDD)

Scoring System: a = unable to evaluate
0 = absent
1 = mild or intermittent
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview.
No score should be given if symptoms result from physical disability or illness.

A. Mood-Related Signs

1. Anxiety anxious expression, ruminations, worrying	a	0	1	2
2. Sadness sad expression, sad voice, tearfulness	a	0	1	2
3. Lack of reactivity to pleasant events	a	0	1	2
4. Irritability easily annoyed, short-tempered	a	0	1	2

B. Behavioral Disturbance

1. Agitation restlessness, handwringing, hairpulling	a	0	1	2
2. Retardation slow movements, slow speech, slow reactions	a	0	1	2
3. Multiple physical complaints (score 0 if GI symptoms only)	a	0	1	2
4. Loss of interest less involved in usual activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

C. Physical Signs

1. Appetite loss eating less than usual	a	0	1	2
2. Weight loss score 2 if greater than 5 lb. in one month	a	0	1	2
3. Lack of energy fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

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D. Cyclic Functions

1. Diurnal variation of mood symptoms worse in the morning	a	0	1	2
2. Difficulty falling asleep later than usual for this individual	a	0	1	2
3. Multiple awakenings during sleep	a	0	1	2
4. Early-morning awakening earlier than usual for this individual	a	0	1	2

E. Ideational Disturbance

1. Suicide feels life is not worth living, has suicidal wishes or makes suicide attempt	a	0	1	2
2. Poor self-esteem self-blame, self-deprecation, feelings of failure	a	0	1	2
3. Pessimism anticipation of the worst	a	0	1	2
4. Mood-congruent delusions delusions of poverty, illness or loss	a	0	1	2

Scoring:

A score >10 probably major depressive episode
A score >18 definite major depressive episode

**How to obtain permission to use the
Cornell Scale for Depression in Dementia:**

George Alexopoulos, M.D.
New York Hospital—Cornell Medical Center
Westchester Division
21 Bloomingdale Road
White Plains, NY 10605

OR

Elsevier Science
Subsidiary Right Dept.
P.O. Box 800
Oxford OX5 1DX
United Kingdom

Functional Activities Questionnaire

Administration

Ask informant to rate patient's ability using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

Writing checks, paying bills, balancing checkbook	
Assembling tax records, business affairs, or papers	
Shopping alone for clothes, household necessities, or groceries	
Playing a game of skill, working on a hobby	
Heating water, making a cup of coffee, turning off stove after use	
Preparing a balanced meal	
Keeping track of current events	
Paying attention to, understanding, discussing TV, book, magazine	
Remembering appointments, family occasions, holidays, medications	
Traveling out of neighborhood, driving, arranging to take buses	
TOTAL SCORE:	

Evaluation

Sum scores (range 0-30). Cutpoint of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.

Pfeffer RI et al. Measurement of functional activities in older adults in the community. J Gerontol 1982; 37(3):323-329. Reprinted with permission of The Gerontological Society of America, 1030 15th Street NW, Suite 250, Washington, DC 20005 via Copyright Clearance Center, Inc.

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Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now. 10 years ago was in 19___. Below are situations where this person has to use his/her memory or intelligence and we want you to indicate whether this has improved, stayed the same or got worse in that situation over the past 10 years. Note the importance of comparing his/her present performance with 10 years ago. So if 10 years ago this person always forgot where he/she had left things, and he/she still does, then this would be considered "Hasn't changed much". Please indicate the changes you have observed by circling the appropriate answer.

Compared with 10 years ago how is this person at:

	1	2	3	4	5
1. Remembering things about family and friends e.g. occupations, birthdays, addresses	Much improved	A bit improved	Not much change	A bit worse	Much worse
2. Remembering things that have happened recently	Much improved	A bit improved	Not much change	A bit worse	Much worse
3. Recalling conversations a few days later	Much improved	A bit improved	Not much change	A bit worse	Much worse
4. Remembering his/her address and telephone number	Much improved	A bit improved	Not much change	A bit worse	Much worse
5. Remembering what day and month it is	Much improved	A bit improved	Not much change	A bit worse	Much worse
6. Remembering where things are usually kept	Much improved	A bit improved	Not much change	A bit worse	Much worse
7. Remembering where to find things which have been put in a different place from usual	Much improved	A bit improved	Not much change	A bit worse	Much worse
8. Knowing how to work familiar machines around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse

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Example for class use only – not for clinical usage. Refer to original source for current form to use.

9. Learning to use a new gadget or machine around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
10. Learning new things in general	Much improved	A bit improved	Not much change	A bit worse	Much worse
11. Following a story in a book or on TV	Much improved	A bit improved	Not much change	A bit worse	Much worse
12. Making decisions on everyday matters	Much improved	A bit improved	Not much change	A bit worse	Much worse
13. Handling money for shopping	Much improved	A bit improved	Not much change	A bit worse	Much worse
14. Handling financial matters e.g. the pension, dealing with the bank	Much improved	A bit improved	Not much change	A bit worse	Much worse
15. Handling other everyday arithmetic problems e.g. knowing how much food to buy, knowing how long between visits from family or friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
16. Using his/her intelligence to understand what's going on and to reason things through	Much improved	A bit improved	Not much change	A bit worse	Much worse

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.

A score ≥ 10 points is almost always indicative of depression.

A score > 5 points should warrant a follow-up comprehensive assessment.

Source: <https://web.stanford.edu/~yesavage/GDS.html>

This scale is in the public domain.

The Hartford Institute for Geriatric Nursing would like to acknowledge the original author of this Try This, Lenore Kurlowicz, PhD, RN, CS, FAAN, who made significant contributions to the field of geropsychiatric nursing and passed away in 2007.

Geriatric Anxiety Inventory (GAI)

Agree or disagree:

1. I worry a lot of the time.
2. I find it difficult to make a decision.
3. I often feel jumpy.
4. I find it hard to relax.
5. I often cannot enjoy things because of my worries.
6. Little things bother me a lot.
7. I often feel like I have butterflies in my stomach.
8. I think of myself as a worrier.
9. I can't help worrying about even trivial things.
10. I often feel nervous.
11. My own thoughts often make me anxious.
12. I get an upset stomach due to my worrying.
13. I think of myself as a nervous person.
14. I always anticipate the worst will happen.
15. I often feel shaky inside.
16. I think that my worries interfere with my life.
17. My worries often overwhelm me.
18. I sometimes feel a great knot in my stomach.
19. I miss out on things because I worry too much.
20. I often feel upset.

This instrument can be found on page 16 of "Development and validation of the Geriatric Anxiety Inventory.", available online at: https://espace.library.uq.edu.au/view/UQ:7924/gb_ig.pdf

Pachana, N., Byrne, G., Siddle, H., Koloski, N., Harley, E., & Arnold, E. (2007). Development and validation of the Geriatric Anxiety Inventory. *International Psychogeriatrics*, 19, 103-114.

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Geriatric Anxiety Scale (GAS)

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Below is a list of common symptoms of anxiety or stress. Please read each item in the list carefully. Indicate how often you have experienced each symptom during the PAST WEEK, INCLUDING TODAY by checking under the corresponding answer.

	Not at all (0)	Sometimes (1)	Most of the time (2)	All of the time (3)
1. My heart raced or beat strongly.				
2. My breath was short.				
3. I had an upset stomach.				
4. I felt like things were not real or like I was outside of myself.				
5. I felt like I was losing control.				
6. I was afraid of being judged by others.				
7. I was afraid of being humiliated or embarrassed.				
8. I had difficulty falling asleep.				
9. I had difficulty staying asleep.				
10. I was irritable.				
11. I had outbursts of anger.				
12. I had difficulty concentrating.				
13. I was easily startled or upset.				
14. I was less interested in doing something I typically enjoy.				
15. I felt detached or isolated from others.				
16. I felt like I was in a daze.				
17. I had a hard time sitting still.				
18. I worried too much.				
19. I could not control my worry.				
20. I felt restless, keyed up, or on edge.				
21. I felt overly tired.				
22. My muscles were tense.				
23. I had back pain, neck pain, or muscle cramps.				
24. I felt like I had no control over my life.				
25. I felt like something terrible was going to happen to me.				
26. I was concerned about my finances.				
27. I was concerned about my health.				
28. I was concerned about my family or children.				
29. I was afraid of dying.				
30. I was afraid of becoming a burden to my family or children.				

Example for class use only – not for clinical usage. Refer to original source for current form to use.