Locations for Geriatrics Assessment

- Ambulatory (aka clinic visit)
- Emergency room
- Hospital
- Nursing home
- Home
Domains of Geriatrics

Assessment

- Functional status:
  - Activities of daily living (ADLs)
  - Mobility
- Nutrition
- Vision
- Hearing
- Cognitive function
- Depression
### Functional Status: Activities of Daily Living

<table>
<thead>
<tr>
<th>Basic ADLs</th>
<th>Instrumental ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Using the telephone</td>
</tr>
<tr>
<td>Dressing</td>
<td>Preparing meals</td>
</tr>
<tr>
<td>Transfer</td>
<td>Managing finances</td>
</tr>
<tr>
<td>Toileting</td>
<td>Taking medications</td>
</tr>
<tr>
<td>Grooming</td>
<td>Laundry</td>
</tr>
<tr>
<td>Feeding oneself</td>
<td>Housekeeping</td>
</tr>
<tr>
<td></td>
<td>Shopping</td>
</tr>
<tr>
<td></td>
<td>Transportation</td>
</tr>
</tbody>
</table>
Functional Status: Mobility

- Mobility:
  - Transfer
  - Gait
  - Balance

- Testing for mobility:
  - Timed up and go test (aka Get up and go)
  - Tandem gait

- Gait abnormalities:
  - Path deviation
  - Diminished step height or length
  - Trips
  - Slips
  - Near falls
  - Difficulty turning
Nutrition

- BMI < 20
- Unintentional weight loss (>10lbs or 5% of your body weight over 6 months)
- Medical illness
- Depression
- Dementia
- Inability to shop or cook
- Inability to feed oneself
- Financial hardship
- Ill fitting dentures
- No teeth
- Tooth pain
- Oral candidiasis
Vision

- Difficulty with driving
- Watching television
- Reading
- Read magazine
- Snellen chart
Bilateral

High frequency

Screening test
  - Whisper voice test
  - Finger rub
Cognitive function

- Why is it important to assess?
  - Most people with dementia won’t complain of memory loss or volunteer symptoms unless asked

- Screening test
  - 3 word recall
  - 3 word recall plus orientation
  - Mini mental status exam (MMSE)
  - Score 21-24:  mild dementia
  - Score 10-20:  moderate dementia
  - Score \( \leq 9 \):  severe dementia
  - Score <24 warrants further evaluation
  - Parts of MMSE: Orientation, registration, recall, attention, language, repetition and commands
MINI-MENTAL STATE EXAMINATION (MMS)

MAXIMUM SCORE | ACTUAL SCORE
---------------|-------------
5              | (     )     
5              | (     )     

ORIENTATION
What is the YEAR, SEASON, DATE, DAY and MONTH?
Where are we? STATE, COUNTY, CITY or TOWN, HOSPITAL, FLOOR?

REGISTRATION
Name 3 common objects (APPLE, TABLE and PENNY):
Take 1 second to say each. Then ask the patient to repeat them
after you have said them. Give 1 point for each correct answer.
Then repeat them until he/she learns all 3.

ATTENTION AND CALCULATION
5              | (     )     

Spell “WORLD” backwards. The score is the number of letters in
correct order (D_ E_ R_ O_ L_ W_).

RECALL
Ask for the 3 objects repeated above. Give 1 point for each correct.
(NOTE: recall cannot be tested if all 3 objects not remembered
during registration.)

LANGUAGE
2              | (     )     

Name a “PENCIL” and “WATCH” (2 points)
Repeat the following:
“No ifs, ands, or buts.” (1 point)
Follow a 3 stage command:
“Take a paper in your right hand,
fold it in half, and
put it on the floor.” (3 points)
Read and obey the following:
1              | (     )     
1              | (     )     
1              | (     )     
“Close your eyes.” (1 point)
“Write a sentence.” (1 point)
“Copy the following design.” (1 point)

No construction problem

TOTAL SCORE: _____

Adapted from Folstein MF, Folstein SE and McHugh PR. “Mini-Mental State”: a practical method for grading the cognitive state of patients
Cognitive function

- Minicog
  - Consist of the clock drawing test and 3 item recall
  - Score 0-2: positive for dementia
  - Score 3-5: negative for dementia

- Alternative executive function
  - Name as many 4 legged animals <1 minute
  - <8-10 animals suggest further evaluation
Depression

- PHQ2: anhedonia
  sadness/depressed

- PHQ9: Mnemonic “SIGECAPS”
  - Sleep
  - Interest
  - Guilt
  - Energy
  - Concentration
  - Appetite
  - Psychomotor agitation or retardation
  - Suicide