Geriatrics Assessment

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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

Basic ADLs	Instrumental ADLs
Bathing	Using the telephone
Dressing	Preparing meals
Transfer	Managing finances
Toileting	Taking medications
Grooming	Laundry
Feeding oneself	Housekeeping
	Shopping
	Transportation

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

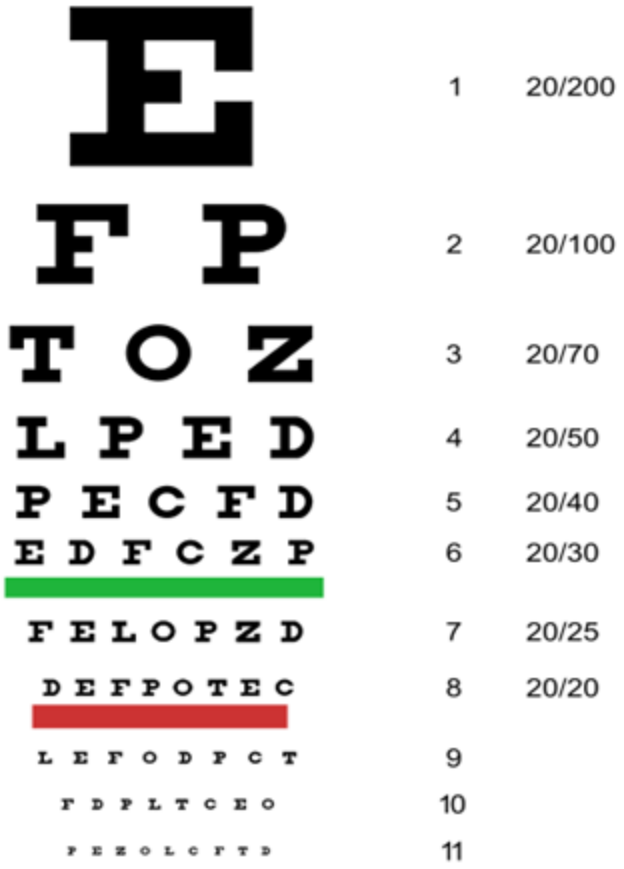
Nutrition

- 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

Snellen chart



Hearing

- 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 ≤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	
		ORIENTATION
5	( )	What is the YEAR, SEASON, DATE, DAY and MONTH?
5	( )	Where are we? STATE, COUNTY, CITY or TOWN, HOSPITAL, FLOOR?
		REGISTRATION
3	( )	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 CALULATION
5	( )	Spell "WORLD" backwards. The score is the number of letters in correct order (D_ L_ R_ O_ W_).
		RECALL
3	( )	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)
3	( )	Repeat the following: "No ifs, ands, or buts." (1 point)
3	( )	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	( )	"Close your eyes." (1 point)
1	( )	"Write a sentence." (1 point)
1	( )	"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"
  - **S**leep
  - **I**nterest
  - **G**uilt
  - **E**nergy
  - **C**oncentration
  - **A**ppetite
  - **P**sychomotor agitation or retardation
  - **S**uicide