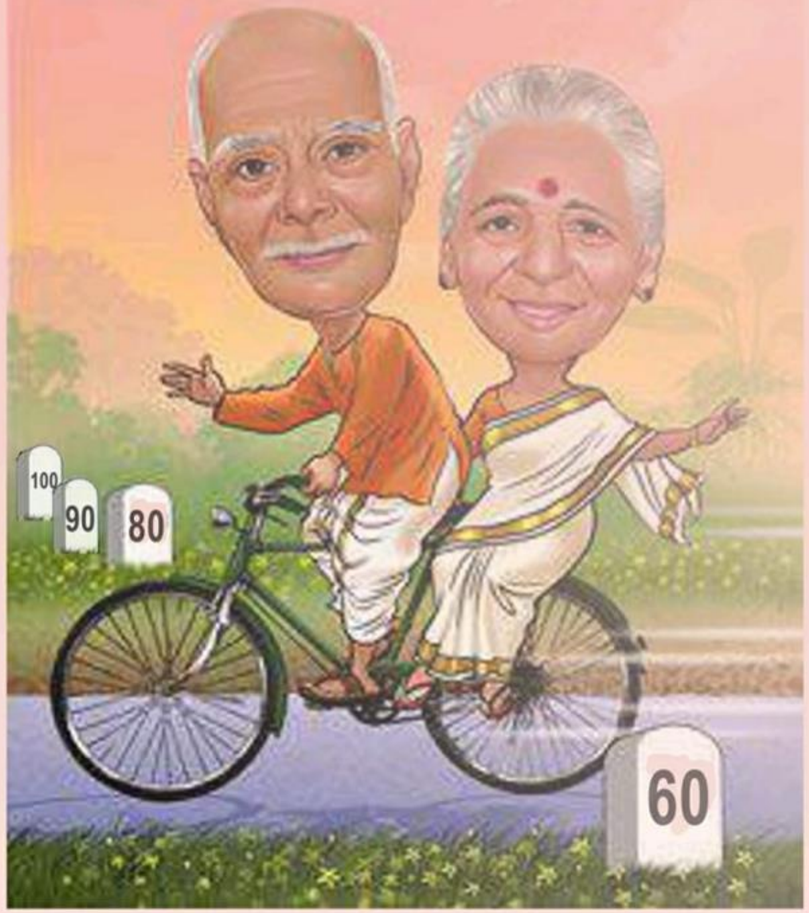
Comprehensive Geriatric Assessment

For MO

COMPREHENSIVE GERIATRIC ASSESSMENT BOOKLET



NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY
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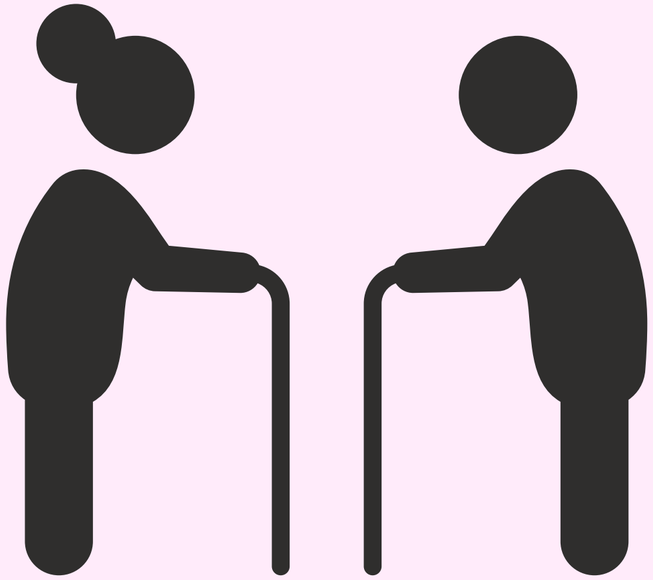
COMPREHENSIVE GERIATRIC ASSESSMENT (CGA)

Definition

- Multidimensional
- Interdisciplinary
- Diagnostic process
- Intended to determine a frail older person's medical, psychosocial, and functional capabilities and problems.

Objective

- Plan for treatment
- Long-term follow-up



LEARNING OBJECTIVES - CGA

- **What - CGA**
- Who - Will do it? PHC MO with ASHA, CHO, MPW, Staff nurse.
- How - History, exam, forms
- Why - To assess (frail) elder totally.
- Where - Periphery (village, sub-centre, PHC)
- Whom - Frail, 75 years or more

DIMENSIONS OF GERIATRIC ASSESSMENT

- Physical health
- Functional status
- Psychological health, including cognitive and affective status
- Socio-environmental factors


Screening for GeriatricGiants
Nutritional Assessment
Socioeconomic status assessment
Comprehensive Geriatric Assessment
Medication optimisation
Comorbidity assessment and optimisation
Functional status assessment

Comprehensive Geriatric Assessment Process	• ASHA • Part B3 of the CBAC is ‘Yes’, and informs MPW (F/M)
Field level	• MPW(F/M) • Conducts section 1 and 2 CGA-CPHC • Section 1 and 2 CGA
Sub Centre HWC level	• CHO • Conducts session 3 and 4 of CGA-CPHC
PHC level	• Medical Officer • Conducts session 3 • Conducts section 5

COMMUNITY BASED ASSESSMENT CHECKLIST (CBAC)

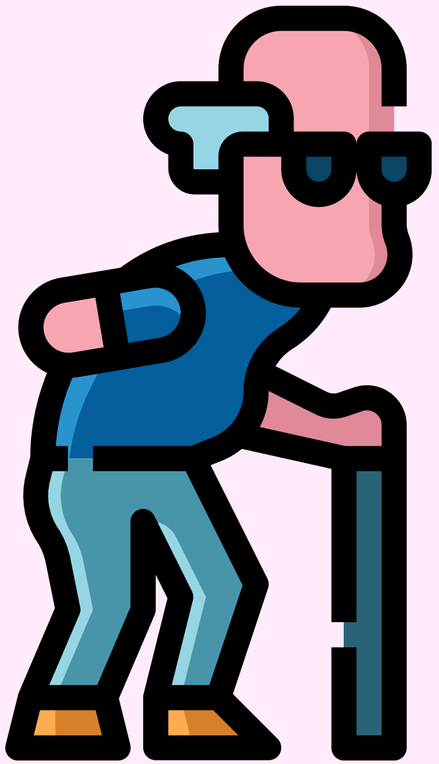
Filled by ASHA

B3: Elderly Specific (60 years and above)			
	Y/N		Y/N
Do you feel **unsteady** while standing or walking?		Do you **need help** from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?	
Are you suffering from any **physical disability** that restricts your movement		Do you **forget** names of your near ones or your own home address	

WHO SHOULD GET PRIORITY FOR CGA ?

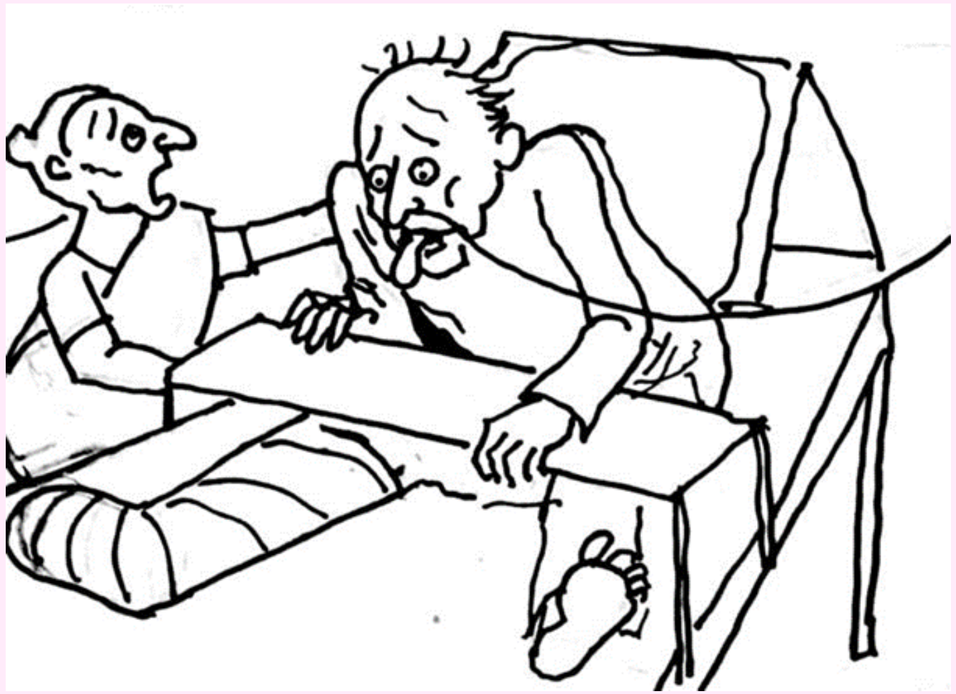
Elder with 1 or more “geriatric Giants” (Red flag signs)

- Age >75 years
- Needs help with Activities of Daily Living
- Lives alone
- History of falls
- History of delirium/confusion
- History of incontinence
- More than 2 admissions to acute care hospital/year
- Failure to thrive



BENEFITS OF CGA

- Decreases patient becoming home-bound
- Helps in management of “geriatric syndromes” such as cognitive impairment, urinary incontinence and falls
- Enhances health and functional outcomes
- Reduces readmissions to hospital
- Facilitates effective discharge planning



Components of Advanced Comprehensive Geriatric Assessment Tool

Section 1: Basic details	A. Registration details B. Identification data of elderly person
Section 2: History taking	A. Chief Complaint B. Details of Complaint C. Personal History D. Past Medical History E. Drug History F. Consumption of addictive substance G. Nutritional History H. Family History I. Social & Spiritual History J. Home safety Environment

OVERVIEW OF COMPONENTS OF CGA

Section 3: 10 Minute comprehensive screening	A. Screening for Geriatric Syndromes B. Screening for other age related problems C. Functional Assessment
Section 4: Physical Examination	A. General Examination B. Systemic Examination
Section 5 : Syndromic specific toolkit for assessment of the problem identified in section 3	A. Screening for memory Loss & cognitive impairment B. Screening for depression C. Fall risk evaluation D. Incontinence assessment & Management guide
Section 6 : Comprehensive Geriatric Assessment report	

Section I

A. Registration Details

1. Date of First Assessment:
2. Name of Health worker/Assessor:
3. Designation of Health worker/Assessor:
4. Contact No.:

B. Identification data of elderly person

5. Name: .....
6. Age (In Completed Years): .....
7. Sex: 1. Male 2. Female 3. Others
8. Address/ Contact:
9. Name/Relationship of Contact Person:
10. Marital Status:

1. Never Married	2. Currently Married	3. Divorced	4. Separated	5. Widowed

11. Who is Head of the family?

1. Myself	2. Wife	3. Son	4. Daughter in law	5. Others .....

12. Education:

1. Illiterate	2. Just literate (knows to read and write but nil education	3. Primary school (5th completed	4. Middle school (8th completed)	5. High school (10th completed	6. Senior secondary (12th completed	7. Graduate	8. Postgraduate

13. Occupation:

    1. Not working; 2. Working (Specify) .....

14. Religion:

1. Hindu	2. Muslim	3. Christian	4. Sikh	5. Others (Specify).....

15. What kind of locality is your house in?

    1. Urban (Specify) ..... 2. Rural (Specify) .....

16. Type of Family: 1. Single 2. Nuclear 3. Joint 4. Elderly homes
17. Total Family income per month? /Rs. .....

    a. Total number of family members? .....

    b. Per capita Income per month: Rs.....

18. Are you Married/Unmarried/Windowed/Seperated/Divorced? (tick whichever is applicable)
19. Are you living with your spouse/children/relatives/alone? (tick whichever is applicable)

20. Are you financially completely independent/partially dependent/completely dependent?
21. What is your perception about behavior of family members with you? Positive/ Negative
22. Do you get pension from anywhere? Yes/No, if yes,
    a. Name the source:
    b. Amount (in rupees):
23. Do you get monetary assistance from any other welfare scheme? Yes/No, if yes
    a. Name the scheme/source:
    b. Amount (in rupees):
24. Do you have any health insurance? Yes/No, if yes, name the source: (if yes specify.....)
25. Have you received any monetary assistance from any NGOs/Religious Organization.
26. Do you know about any health insurance scheme for elderly by Government? Yes/No
27. Do you know about any helpline number for elderly in your city? Yes/No

Section II: History Taking

A. Chief Complaint

1. .....
2. .....
3. .....
4. .....
5. .....

B. Details of complaints

B1. Do you have any eye complaints?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Do you use spectacles?		Yes/ No
If Yes, mention the power of the lens. Right Eye: Left Eye:		
Eye Symptoms	Response	Duration
Diminished Vision (Near/ Distant)	Yes/ No	
Visual blurring/ Double vision/ Distorted vision (straight lines become crooked/magnified/diminished)	Yes/ No	
Pain in the eye	Yes/ No	
Itching/ foreign body sensation in the eye/ Burning/ Stinging sensation	Yes/ No	

Section II: History Taking

A. Chief Complaint

1. .....
2. .....
3. .....
4. .....
5. .....

B. Details of complaints

B1. Do you have any eye complaints?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Do you use spectacles?		Yes/ No
If Yes, mention the power of the lens. Right Eye: Left Eye:		
Eye Symptoms	Response	Duration
Diminished Vision (Near/ Distant)	Yes/ No	
Visual blurring/ Double vision/ Distorted vision (straight lines become crooked/magnified/diminished)	Yes/ No	
Pain in the eye	Yes/ No	
Itching/ foreign body sensation in the eye/ Burning/ Stinging sensation	Yes/ No	

Discharge from eyes	Yes/ No	
Any Other, specify:		

B2. Do you have any complaints related to Ear-Nose-Throat?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
ENT Symptoms	Response	Duration
Earache	Yes/ No	
Ear Discharge	Yes/ No	
Hearing Loss	Yes/ No	
Tinnitus (ringing, rushing or hissing sound in the absence of any external sound)	Yes/ No	
Dizziness/ Vertigo	Yes/ No	
Hoarseness of voice (Sudden or Gradual)		
Nasal Discharge		
Any other, specify:		

B3. Do you have any complaints related to oro-dental condition?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Oro-dental Symptoms	Response	Duration
Bad Breath	Yes/ No	
Visible pits or holes in the teeth/loose teeth	Yes/ No	
Aggravation of pain with exposure to heat, cold or sweet foods and drinks	Yes/ No	
Red swollen gums, tender and bleeding gums	Yes/ No	
Ulcer/ Sore in the mouth that does not healt/ Red or white patches inside the mouth	Yes/ No	
Difficulty in opening the mouth	Yes/ No	
Pain while swallowing	Yes/ No	
Any other, specify		

B4. Do you have any cardiac or respiratory symptoms?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Cardio-Respiratory Symptoms	Response	Duration
Breathlessness	Yes/ No	
Cough Expectoration	Yes/ No	

Presence of blood in cough	Yes/ No	
Noise coming from chest (audible wheeze)	Yes/ No	
Chest pain	Yes/ No	
Any other, specify:		

B5. Do you have any Gastro-intestinal Symptoms		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Gastro-Intestinal Symptoms	Response	Duration
Difficulty in swallowing	Yes/ No	
Heartburn	Yes/ No	
Indigestion	Yes/ No	
Constipation/ Diarrhoea/ Alteration of bowel pattern	Yes/ No	
Abdominal pain/ distension	Yes/ No	
Bleeding during or after defecation		
Any other, specify:		

B6. Do you have any Genito-urinary complaints?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Genito-urinary Symptoms	Response	Duration
Pain in the lower part of the belly	Yes/ No	
Pain or burning sensation while passing time	Yes/ No	
Do you have to repeatedly visit washroom to pass urine?	Yes/ No	
Difficulty in initiating urination	Yes/ No	
Passing urine while coughing or sneezing	Yes/ No	
Discharge from external genital region	Yes/ No	
Any other, specify:		

B7. Do you have any skin related problems?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Skin related Symptoms	Response	Duration
Itching	Yes/ No	
White/light coloured patches	Yes/ No	
Dark/ coloured patches	Yes/ No	
Ulceration/ Soreness/ open wound	Yes/ No	

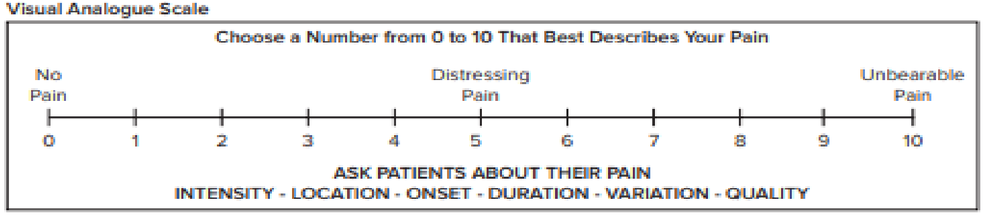
Skin eruptions filled with fluid	Yes/ No	
Any other, specify:		

B8. Dou you have any complaints suggestive of neurological problem?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Neurological Symptoms	Response	Duration
Increased difficulty in remembering	Yes/ No	
Headache	Yes/ No	
Loss of awareness regarding time, place and person	Yes/ No	
Loss of balance/falls/weakness	Yes/ No	
Involuntary movements of parts of body-tremors/ inability to control limbs	Yes/ No	
Pain/ altered sensation	Yes/ No	
Any other, specify:		

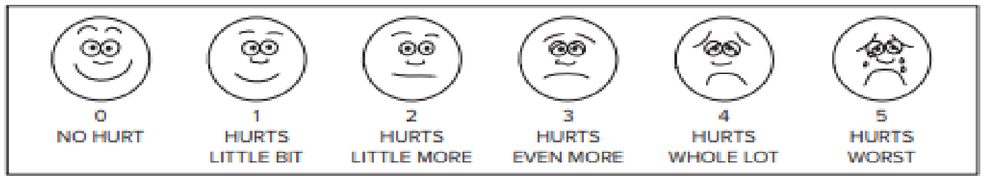
B9. Do you have any complaints related to muscles, bones or joints?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Musculo-skeletal symptoms	Response	Duration
Pain or stiffness in muscles, joints or back	Yes/ No	
Any swelling in joints?	Yes/ No	
Difficulty in carrying out normal activities	Yes/ No	
Difficulty in walking up and down stairs	Yes/ No	
Any other, specify:		

Tool Commonly used to Rate Pain

Visual Analogue Scale



"Faces" Pain Rating Scale



NOTE: Ask Females Only B10. Do you have any gynecological symptoms?		Yes/ No
If Yes, have you consulted any doctor for this problem?		Yes/ No
Gynecological Symptoms	Response	Duration
Bleeding per vagina	Yes/ No	
Discharge per vagina	Yes/ No	
Swelling/mass felt at the genital region	Yes/ No	
Pain in the lower part of the belly	Yes/ No	
Any history of surgical removal of womb (hysterectomy)?	Yes/ No	
Have you ever been screened for: A) Breast Cancer/ SBE/ Memmogram B) Cervical Cancer/ VIA-VILI/ Colposcopy/ PAP SMEAR	Yes/ No	
Any other, specify:		

C. Past medical History

Is on treatment for	Duration of illness	Current medication & dosage	Verification of records	In case of treatment completion or stoppage, mention since how long
Diabetes Mellitus			Yes/ No	
Hypertension			Yes/ No	
Thyroid Disease			Yes/ No	
Chronic Kidney Disease			Yes/ No	
Tuberculosis			Yes/ No	
Any other respiratory disease, specify			Yes/ No	
Cardiac condition Specify.....			Yes/ No	
Musculoskeletal condition Specify.....			Yes/ No	
Neurological Condition Specify.....			Yes/ No	
Psychiatric Disorder Specify.....			Yes/ No	
Dental disorder Specify.....			Yes/ No	
Any other condition Specify.....			Yes/ No	

Has any vaccine taken during the past 5 years? Yes/ No. If Yes, please specify:

Vaccine..... Date received .....

Vaccine..... Date received .....

Vaccine..... Date received ..... \

History of recent hospitalization (previous one year): Yes/ No

If yes, specify the reasons below:

D. Drug History

S. No.	QUESTION	RESPONSE (tick appropriate answer wherever applicable)
1	Are you taking any medication?	Yes/NO If Yes, No. Of medicines taken daily:
2	Are you taking any medications without consulting the doctor?	Yes/No If Yes, Nmae the condition for which medicine is being taken:
3	Are you suffering from any drug side effects?	Yes/No If Yes, please specify:
4	Are you taking any medicines other than allopathy?	Ayurveda/Homeopathy/Unani/ Any other/ None
5	Do you use a pill organizer?	Yes/No

E. Consumption of additive substances

Additive Substances (tick 'Y' for yes and 'N' for no)		If yes, specify duration (in weeks or months or years)	Standard quantity	Quantity consumed (Fill any one)	If stopped, specify duration since last consumption
Tobacco					
Smokeless & chewable (Eg. gutka, khaini, paan masala, zarda, betel quid)	Y/N		No. Of packets	Per day... OR Per week.... OR Per Month... OR Occasionally	
Snuff	Y/N			Per day... OR Per week.... OR Per Month... OR Occasionally	

Additive Substances (tick 'Y' for yes and 'N' for no)		If yes, specify duration (in weeks or months or years)	Standard quantity	Quantity consumed (Fill any one)	If stopped, specify duration since last consumption
Smoking (Eg. Cigarette, beedi, cigar, hookah)	Y/N		No. Of pieces/ packets	Per day... OR Per week.... OR Per Month... OR Occasionally	
Alcohol	Y/N		One small peg= 30ml	Per day... OR Per week.... OR Per Month... OR Occasionally	
Opioids ('Afeem' or 'Doda' or 'Amal')	Y/N			Per day... OR Per week.... OR Per Month... OR Occasionally	
Sleeping pills	Y/N		No. of pills	Per day... OR Per week.... OR Per Month... OR Occasionally	
Painkillers	Y/N		No. of pills	Per day... OR Per week.... OR Per Month... OR Occasionally	
Cannabis (Ganja/Bhang)	Y/N			Per day... OR Per week.... OR Per Month... OR Occasionally	
Any other, specify:					






F. Nutritional History

Complete the screening by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening	
A Has food intake declined declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? 0 = severe decrease in food intake 1 = moderate decrease in food intake 2 = no decrease in food intake	☐
B Weight loss during the last 3 months 0 = weight loss greater than 3 kg (6.6 ibs) 1 = does not know 2 = weight loss between 1 and 3 kg (2.2 and 6.6 ibs) 3 = no weight loss	☐
C Mobility 0 = bed or chair bound 1 = able to get out of bed / chair but does not go out 2 = goes out	☐
D Has suffered psychological stress or acute disease in the past 3 month? 0 = yes 2 = no	☐
E Neuropsychological problems 0 = severe dementia or depression 1 = mild dementia 2 = no psychological problems	☐
F1 Body Mass Index (BMI) (weight in kg) / (height in m)² 0 = BMI less than 19 1 = BMI 19 to less than 21 2 = BMI 21 to less than 23 3 = BMI 23 or greater	☐
IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2. **DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.**	
F2 Calf circumference (CC) in cm 0 = CC less than 31 3 = CC 31 or greater	☐
Screening score (max. 14 points)	☐☐
12-14 points: ☐ Normal nutritional status	
8-11 points: ☐ At risk of malnutrition	
0-7 points: ☐ Malnourished	

Nutrional Diversity

Food item	Examples	Frequency of consumption(tick the appropriate answer)		Remarks
		Daily	weekly	
Cereals	Wheat, wheat flour (atta/maida), rice (brown/white), rice flakes (chiwra), maize/corn, barley, oats, suji, vermicelli (sevian), puffed rice, etc			
Millets	Bajra, Ragi, Jowar			
Pulses	Bengal gram (channa dal), Bengal gram flour (besan), green gram (moong dal), black gram (urad dal), arhar dal (tur dal) chickpea (white/ black/green chana), sprouted pulses, legumes like rajma, lobia, soyabean and its products, etc.			
Vegetables and fruits	Green leafy vegetables - spinach, mustard leaves (sarson), fenugreek leaves, bathua, coriander leaves etc; Other vegetables - carrots, onion, brinjal, ladies finger, cucumber, cauliflower, tomato, capsicum, cabbage etc; **Starchy roots and tubers - potatoes, sweet potatoes, yam, colocasia and other root vegetables; Fruits - Mango, guava, papaya, orange, sweet lime, watermelon, lemon, grapes, amla, etc			
Milk	Milk, curd, skimmed milk, cheese, cottage cheese (paneer), etc			
Animal products	Meat, egg, fish, chicken, liver, etc.			
Oils, Fats, Sugar and Nuts	Oils and Fats - Butter, ghee, vegetable cooking oils like groundnut oil, mustard oil, coconut oil, etc; Sugars - Sugar, jaggery, honey; Nuts - peanuts, almonds, cashew nuts, pistachios, walnuts, etc.			

*These examples will change according to local crops and diets in different areas ** Starchy roots and tubers like potatoes, sweet potatoes (shakarkandi), yam (jimikand), colocasia (arbi) and other root vegetables; as well as fruits like banana are rich in starch which provide energy

Ask the following questions:

a. Number of meals taken per day.....Veg/Non Veg, Frequency of Non Veh..
b. Quantity of water/ juice and other fluid consumed per day (in litres/in glasses)..
c. History of loss of weight (e.g. Loosening of clothes) Yes/No
d. If weight loss present, mention how much weight was lost in the past one month..
e. History of reduced appetite: Yes/No (If yes, give reason)
f. Difficulty in chewing food: Yes/No (If yes, give reason)
g. Difficulty in swallowing food: Yes/No (If yes, give reason)
h. Does the elderly person feed with some assistance: Yes/No
i. Consumption of additional sources of salt (e.g. Pickle, chutney, papad, ready to eat food): Yes/No (If Yes, specify: .....)
j. Who prepares the food at home? (self/daughter/daughter in law/any other caregiver)

G. Family History

Hypertension	Diabetes	Heart Disease	Dementia	Cancer

Ha. Family support

Married:	Yes	No
Spouse living	Yes	No
Living with		
No of Children		
How often do you see them?		
Who assists you?		
Is the assistance sufficient?	Yes	No
Native Language		
Type of House	Independent	Apartment
Stairs	Present	Absent
Who would be able to help the senior citizen of your family in case of illness or emergency?		

Hb. Social and Spiritual assessment

Do you pray, worship or meditate at home or outside? Yes/No If yes, specify

Do you participate in family or community gatherings? Yes/No If yes, specify .....

Do you have any hobbies? Yes/No If yes, specify .....

I. Personal History

Do you exercise daily?	Yes	No
If yes, minutes/ day?		
What type?		

e. History of reduced appetite: Yes/No (If yes, give reason)

f. Difficulty in chewing food: Yes/No (If yes, give reason)

g. Difficulty in swallowing food: Yes/No (If yes, give reason)

h. Does the elderly person feed with some assistance: Yes/No

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Do you pray, worship or meditate at home or outside? Yes/No If yes, specify

Do you participate in family or community gatherings? Yes/No If yes, specify .....

Do you have any hobbies? Yes/No If yes, specify .....

I. Personal History

Do you exercise daily?	Yes	No
If yes, minutes/ day?		
What type?		

Smoker	Yes	No
	Duration	
Alcohol	Yes	No
	Duration	
Caregiver fatigue	Yes	No

J. Home safety Environment

- Ask the senior citizen if he/she has trouble with lighting or with stairs inside or outside the house? Yes/No

Healthcare worker to assess the following

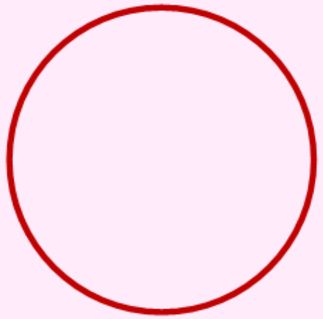
Assessment	Observation (tick the appropriate answer)
Is the bathroom slippery and wet?	Yes/No/Not applicable
Is there any provision for a caregiver at home?	Yes/No/Not applicable
Is there any ramp at home for elderly using walking aids or wheelchairs?	Yes/No/Not applicable
Are there any handrails in the staircase and bathrooms?	Yes/No/Not applicable

Various Syndromes – (Geriatric society guidelines 2005)

- Fall
- Frailty
- Urinary Incontinence
- Anorexia and Malnutrition
- Dementia
- Delirium
- Depression
- Pressure Ulcers
- Sleep Disorders
- Pain
- Immobility

SECTION 3: 10 MINUTE COMPREHENSIVE SCREENING

SCREENING FOR GERIATRIC SYNDROMES

*Memory	3 Objects named	Yes	No	Clock Draw Test 
DEPRESSION(if yes to the question proceed to the Depression Management toolkit)	Are you often sad/depressed?	Yes	No	
FALLS (if yes to first question and not able to walk around chair/if unsteady proceed to fall risk assessment toolkit)	Fallen more than twice in last 1 year	Yes	No	
	Able to walk around chair ?(Check if unsteady)	Yes	No	
URINARY INCONTINENCE (if yes to any one of the above questions, proceed to toolkit on management of Urinary incontinence)	Lost urine / got wet in past one year/ week?	Yes	No	
*MEMORY RECALL	One object	Two objects	Three objects	None
MiniCog Score				

Screen for other age related problems

Vision	Ask:"Do you have difficulty reading or doing any of your daily activities because of your eyesight?"(even with wearing glasses)	If , Yes, Test Vision using - Snellen's/Finger Counting	Right eye	Left eye	If visual impairment present , refer to medical officer/specialist for further assessment
Hearing			Right ear	Left ear	If hearing impairment present , refer to medical officer/specialist for further assessment
6,1,9 test (Stand behind the patient and speak softly and then in normal voice - 6,1, 9 and check for hearing)		Normally			
		Softly			
Have you noticed a change in your weight over the past 6 months?		Yes	No	If YES, Increase= -----kg or Decrease =----kg	
Constipation			Yes	No	Refer to medical officer for further assessment
Insomnia			Yes	No	

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person 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. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

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 in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

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?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

GENERAL PRACTITIONER ASSESSMENT OF COGNITION (GPCOG)

- General Practitioner assessment of cognition (GPCOG)
- Developed in 2002 by Brodaty et al
- For screening for dementia by GPs
- Takes around 4 minutes to administer
- Has two steps
    - Patient interview
    - Informant interview

GPCOG-1

Name and Address for subsequent recall test		
1. "I am going to give you a name and address, 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: Sunil Kishan Mhaske Near Daulatabad Fort Aurangabad.		
(Please tick appropriate box ✓)	Correct ✓	Incorrect x
Time Orientation		
What is the date? (exact only)		
Clock Drawings — Use blank page		
Please mark in all the numbers to indicate the hours of a clock (correct spacing required)		
Please mark in hands to show a certain time ex. 11.10am.		

Information		
Can you tell me something that happened in the news in the last week.		
Recall		
What was the name and address I asked you to remember?		
Sunil		
Mhaske		
Near Daulatabad Fort		
Aurangabad		
(To get a total score, add the numbers of items answered correctly Total Correct (Score out of 9)		/ 9

GPCOG

Has total 9 points

- If patient scores 9 on 9 he is cognitively intact
- If he scores 5 to 8 proceed to informant interviewstep 2
- If score is 4 or less than cognitive decline is very likely (no need to do step 2)

GPCOG-2

CARER INTERVIEW				
Carer's Name				
Carer's relationship to patient i.e. carer is the patient's:				
These 6 questions ask how the patient is compared to when s/he was well, say 5 -10 years ago:				
(Please tick appropriate box ✓)	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 words or tend to use the wrong words more often?				

SCORE 0-3 – COGNITIVE IMPAIRMENT INDICATED

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'				
Scores				
To get a total score, only add the number of items answered 'no', don't know or Not Applicable				

GDS -4

Patient name:.....Age/Sex.....MRD.....Date.....

Address.....Caretaker.....Contact.....

Consent: I have been informed about and giving my permission for the following assessment
Patient's Signature.....

4 ITEM GERIATRIC DEPRESSION SCORE (GDS-4) Score:

1	Are you basically satisfied with your life?	Yes/**NO(1)**	
2	Do you feel your life is empty?	**Yes(1)/**NO	
3	Are you afraid that something bad going to happen you?	**Yes(1)**/NO	
4	Do you feel happy most of the time	Yes/**NO(1)**	

4 Item depression score:...../4

INTERPRETATION

- GDS 4: Depressed
- 2-4 Depression
- 1 – Uncertain (Have to do GDS 15)
- 0 - Not Depressed

GDS -15

Instructions:	Circle the answer that best describes how you 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 things?	**yes**	no
	10. Do you feel that 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 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
	Total Score		

Scoring Instructions:	***Score one point for each bolded answer.*** A score of 5 or more suggests depression.	
	Total Score:	

If positive, follow the depression management flowchart.

Source: Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey MB, Leirer VO. Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research 17:* 37-49, 1983.

Score >=5

DEPRESSED

FALL RISK ASSESSMENT

Part -1

History of Your Falls

(Description of the fall)

We need to hear the details of your falls so we can understand what is causing them. Answer the following questions about your last fall.

I. When was the fall?.....Date and Time of the day.....

II. What were you doing before you fell?

.....

III. Do you remember your fall, or did someone tell you about it?

.....

IV. How did you feel just before?

.....

V. How did you feel going down?

.....

VI. What part of your body hit?

.....

VII. What did it strike?

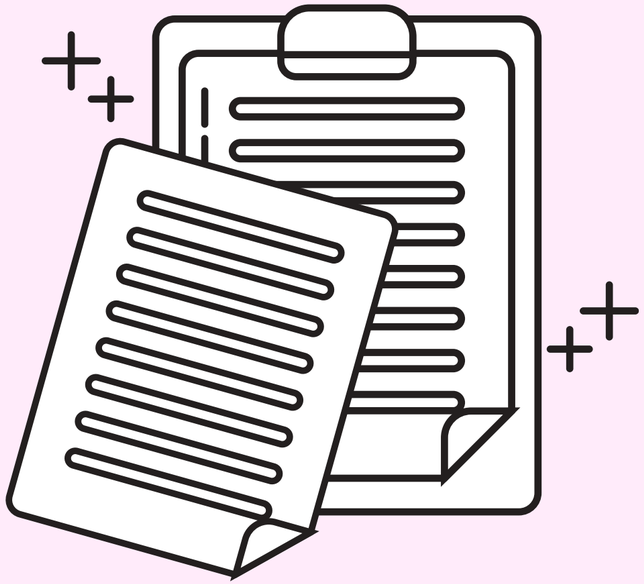
.....

VIII. What was injured?

.....

IX. Anything else you recall?

.....



X. Do you think you passed out?

.....

XI. Do you have joint pain?

.....

XII. Do you have joint instability?

.....

XIII. Do you have foot problems?

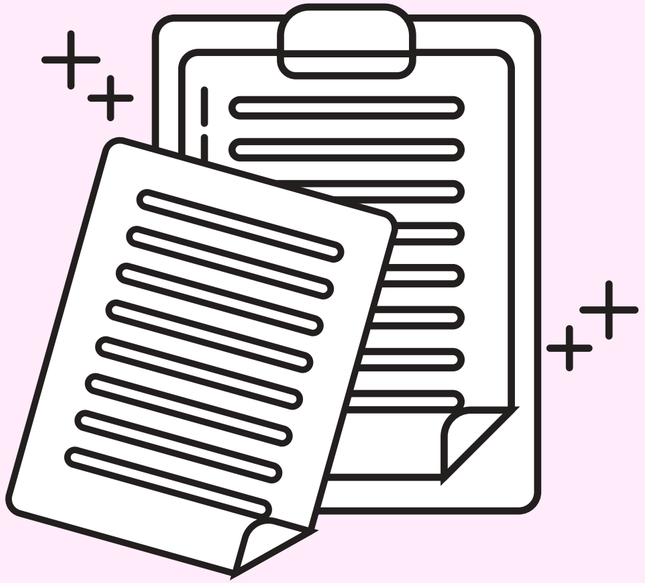
.....

XIV. Do you use a cane/walker?

.....

XV. How often have you fallen in the last six months?

.....



3 IQ: (INCONTINENCE QUESTIONNAIRE)

Single question

- Do you have urinary leak problems since last 3 months?
- If answer is no then end questionnaire
- If answer is yes then 3 questions to be asked:

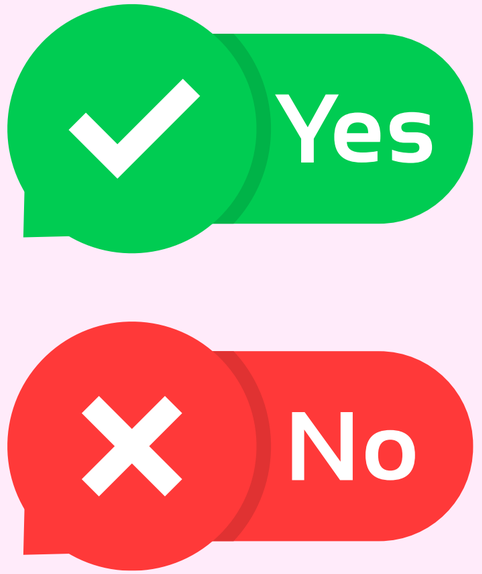
1. Frequent trips to bathroom?
2. Leaking urine on way to bathroom?
3. Leaking during coughing laughing ?

If yes then ask, then detail questionnaire to be asked

KATZ INDEX: BASIC ACTIVITIES OF DAILY LIVING

(Score 1 point for each yes answer)

1. Bath by self	Yes No
2. Dress by self	Yes No
3. Toilet by self	Yes No
4. Transfer from bed to chair	Yes No
5. Continence	Yes No
6. Feeding by self	Yes No



Total score: 6 = High (patient independent) 0 = Low (patient very dependent)

FUNCTIONAL ASSESSMENT

- Physical Functional Capacity (Instrumental Activities of Daily Living-IADLs)
- Lawton Instrumental Activities of Daily Living Scale

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women, and 0 to 5 for men

Are you able to …?		
Run/ Walk fast to catch a bus	Yes	No
Do heavy work at home	Yes	No
Go shopping for groceries/ clothes	Yes	No
Get to places out of walking distance? (drive/take a bus)	Yes	No
Bath using shower/ bucket	Yes	No
Put on clothes / footwear	Yes	No

Mini Nutritional Assessment

MNA®

Nestlé Nutrition Institute

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months

0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility

0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?

0 = yes 2 = no

E Neuropsychological problems

0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F1 Body Mass Index (BMI) (weight in kg) / (height in m^2)

0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm

0 = CC less than 31
3 = CC 31 or greater

Screening score
(max. 14 points)

12-14 points:	☐	Normal nutritional status
8-11 points:	☐	At risk of malnutrition
0-7 points:	☐	Malnourished

Save
Print
Reset

Ref. Vellas B, Villars H, Abellan G, et al. *Overview of the MNA® - Its History and Challenges*. J Nutr Health Aging 2006;10:456-465.

Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. *Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF)*. J. Geront 2001;56A: M366-377.

Guigoz Y. *The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us?* J Nutr Health Aging 2006; 10:466-487.

Kaiser MJ, Bauer JM, Ramsch C, et al. *Validation of the Mini Nutritional Assessment Short-Form (MNA®-SF): A practical tool for identification of nutritional status.* J Nutr Health Aging 2009; 13:782-788.

For more information: www.mna-elderly.com

- BMI = weight (kg)/height (m)2

CLASSIFICATION	BODY MASS INDEX (kg/m2)	OBESITY CLASS	DISEASE RISK
Underweight			
Healthy weight			
Overweight	25.0–29.9	—	Increased
Obesity	30.0–34.9	I	High
Obesity	35.0–39.9	II	Very high
Extreme obesity	≥40	III	Extremely high

- Waist circumference

South Asians and Chinese	
Men	>90 cm (>35 in)
Women	>80 cm (>31.5 in)

EASI (ELDERLY ABUSE SUSPICION INDEX)

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? - 1. Yes 2. No 3. Did Not Answer

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with? -1. Yes 2. No 3. Did Not Answer

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened? -1. Yes 2. No 3. Did Not Answer

4. Has anyone tried to force you to sign papers or to use your money against your will? -1. Yes 2. No 3. Did Not Answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? -1. Yes 2. No 3. Did Not Answer

6. Doctor: Elder abuse may be associated with fndings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? - 1. Yes 2. No 3. Not sure

Note:

- *Q.1-Q.5 asked of patient; Q.6 answered by doctor (Within the last 12 months)*
- 2. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern

CASE 1

A 70 years old female who is a diagnosed case of Type 2 DM on OHA since 10 years, presented with complaints of lethargy, deceased sleep and appetite, confined to her room since last 5 months. The patient's son comments that she seems uninterested in participating in family activities and looks gloomy. Her physical examination and laboratory tests are otherwise unremarkable.

- What is your diagnosis?
- What screening tool can be used in OPD to screen such patients and their cut offs

CASE 2

A 68 years old , female was not able to perform her activities well, for the past few months. She speaks only regional language and is unable to read and write. She works as a housemaid with the same family since 16 years but recently she forgets her way to work and often is found wandering.

- Which Scale is to be used here?

CASE 3

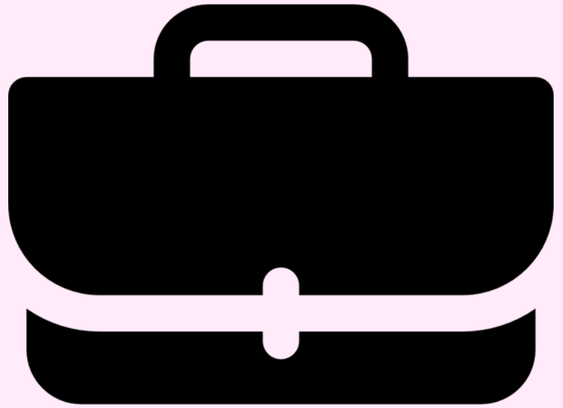
A 75 year old, multiparous female, with H/O Hysterectomy done 5 years back, came to Geriatric OPD with C/O chest pain and palpitations. On screening for incontinence, she gives H/O leaking of some drops of urine during coughing and laughing, occurring occasionally since last 6 months.

- What questions are to be asked for screening for incontinence ?
- What is the type of incontinence in this female patient?

CASE 4

A 70 year old female patient, known case of Cerebro-vascular accident with left hemiplegia since 1 year, is unable to perform bathing, dressing, toileting, transfer to chair or self feeding but her bowel and bladder is continent.

- Which scale will you apply in this scenario?
- What will be score of this patient?
- What is your interpretation?



CASE 5

A 63 year old male was brought to the OPD by his relative with c/o loss of appetite, Generalized weakness since 3 months. On enquiry gives history of loosening of clothes since last 2 months.

Also easy fatiguability on routine work. No history of cough, expectoration. No history of fever.

Personal history of decreased appetite and decreased food intake. Initially he was eating 2 Chapatti and 1 glass of milk (morning) 1 cup of rice & vegetables (lunch) and 2 chapatti (Dinner). since last few days he is eating only 1 chapatti (mor) and ½ cup rice (lunch) & 1/2 glass of milk at night.

- Is this patient Malnourished?
- How will you assess it ?

CASE 6

- A 75 years old male, has come to attend the Geriatric clinic at your hospital for routine medical examination
- He is a diagnosed case of Diabetes and HTN
- His medications include: Tablet Glimeperide 2 mg OD, Tablet Metformin 500 mg BD, Tablet Telmisartan 40 mg OD, Tab. Enalapril 5 mg OD
- On enquiry, it was revealed that he was taking Tablet Alprazolam 0.5 mg HS since 6 months for insomnia
- He also has history of difficulty in urination for which on Tamsulosin at bedtime
- He has been operated for cataract in both eyes, uses spectacles. No hearing impairment
- He had fallen twice in the past 2 month, on getting up from sleep to urinate

1) How will you evaluate this patient?

2) What are your advice to this patient?

3) What are suggestions for modification of living room?

SUMMARY

- CGA is an assessment tool to help get best help for the elderly as soon as possible
- Consists of a CGA tool with 6 sections
- Initial 10 min screening done at sub centre level
- CGA forms –
  - Mini Cog and GP Cog – for dementia
  - GDS -4 and GDS- 15 – for depression
  - Fall risk assessment questionnaire
  - Questionnaire for Urinary Incontinence
  - Katz index - for Activities of daily living
  - Mini nutritional assessment

Thank You