ANNEXURE: 1	Comprehensive Geriatric Assessment Tool		
CHAPTER: 6	Resident Care Services		
MONTH CREATED	December 2024	NEXT REVIEW	December 2026
CHAPTER CODE	RCS	VERSION	1
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Comprehensive Geriatric Assessment Tool

(Source: Training Manual on Elderly Care for Community Health Officer at Ayushman Bharat – Health and Wellness Centres)

S.No	Resident Details	Remarks
A1	Resident /Applicant Name	
A2	Date of Birth & Age	
A3	Gender (Male / Female / Third Gender)	
A4	Resident Room No.	
A5	Occupancy Type (Single / Double / Dormitory)	
A6	Date of Joining	
A7	Date of Discharge	
A8	Date of Transfer	
A9	Date of Demise	

1) Details of complaints:

S.No	Complaint / Issues	Response	
A-1	**Do you have any eye complaints?**	**Yes/No**	
1	If Yes, have you consulted any doctor for this problem?	**Yes/No**	
2	Do you use spectacles?	**Yes/No**	
3	If Yes, mention the power of the lens. Right Eye: Left Eye:		
4	Eye Symptoms	**Response**	**Duration**
5	Diminished Vision (Near/Distant)	**Yes/No**	
6	Visual blurring/Double vision/Distorted vision (straight lines become crooked/magnified/diminished)	**Yes/No**	
7	Pain in the eye	**Yes/No**	
8	Itching/foreign body sensation in the eye/Burning/Stinging sensation	**Yes/No**	
9	Discharge from eyes	**Yes/No**	
10	Any Other, specify:		

S.No	Complaint / Issues	Response	
A-2	**Do you have any complaints related to Ear-Nose-Throat?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	ENT Symptoms	**Response**	**Duration**
3	Earache	**Yes/No**	
4	Ear Discharge	**Yes/No**	
5	Hearing Loss	**Yes/No**	
6	Tinnitus (ringing, rushing or hissing sound in the absence of any external sound)	**Yes/No**	
7	Dizziness/Vertigo	**Yes/No**	
8	Hoarseness of voice (Sudden or Gradual)		
9	Nasal Discharge		
10	Any other, specify:		

S.No	Complaint / Issues		Response
A-3	**Do you have any complaints related to oro-dental condition?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	Oro-dental Symptoms	**Response**	**Duration**
3	Bad Breath	**Yes/No**	
4	Visible pits or holes in the teeth/loose teeth	**Yes/No**	
5	Aggravation of pain with exposure to heat, cold or sweet foods and drinks	**Yes/No**	
6	Red swollen gums, tender and bleeding gums	**Yes/No**	
7	Ulcer/Sore in the mouth that does not healt/Red or white patches inside the mouth	**Yes/No**	
8	Difficulty in opening the mouth	**Yes/No**	
9	Pain while swallowing	**Yes/No**	
10	Any other, specify		

S.No	Complaint / Issues		Response
A-4	**Do you have any cardiac or respiratory symptoms?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	Cardio-Respiratory Symptoms	**Response**	**Duration**
3	Breathlessness	**Yes/No**	
4	Cough Expectoration	**Yes/No**	
5	Presence of blood in cough	**Yes/No**	
6	Noise coming from chest (audible wheeze)	**Yes/No**	
7	Chest pain	**Yes/No**	
8	Any other, specify:		

S.No	Complaint / Issues		Response
A-5	**Do you have any Gastro-intestinal Symptoms?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	Gastro-Intestinal Symptoms	**Response**	**Duration**
3	Difficulty in swallowing	**Yes/No**	
4	Heartburn	**Yes/No**	
5	Indigestion	**Yes/No**	
6	Constipation/Diarrhoea/Alteration of bowel pattern	**Yes/No**	
7	Abdominal pain/distension	**Yes/No**	
8	Bleeding during or after defecation		
9	Any other, specify:		

S.No	Complaint / Issues		Response
A-6	**Do you have any Genito-urinary complaints?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	Genito-urinary Symptoms	**Response**	**Duration**
3	Pain in the lower part of the belly	**Yes/No**	
4	Pain or burning sensation while passing time	**Yes/No**	
5	Do you have to repeatedly visit washroom to pass urine?	**Yes/No**	
6	Difficulty in initiating urination	**Yes/No**	
7	Passing urine while coughing or sneezing	**Yes/No**	
8	Discharge from external genital region	**Yes/No**	
9	Any other, specify:		

S.No	Complaint / Issues		Response
A-7	**Do you have any skin related problems?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	Skin related Symptoms	**Response**	**Duration**
3	Itching	**Yes/No**	
4	White/light coloured patches	**Yes/No**	
5	Dark/coloured patches	**Yes/No**	
6	Ulceration/Soreness/open wound	**Yes/No**	
7	Skin eruptions filled with fluid	**Yes/No**	
8	Any other, specify:		

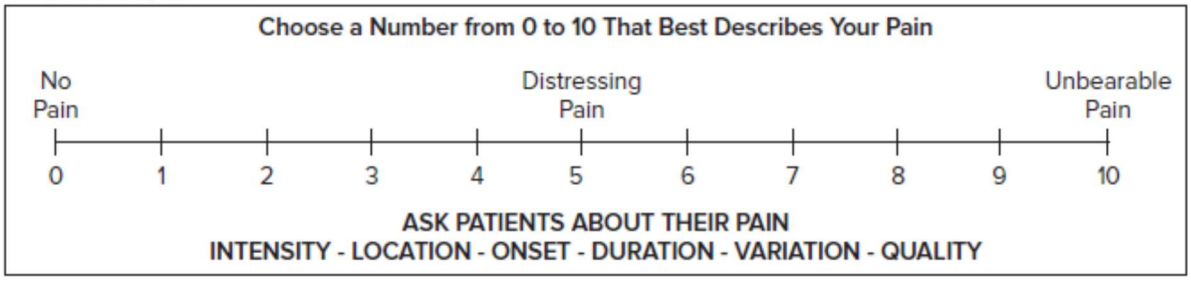
S.No	Complaint / Issues		Response
A-8	**Dou you have any complaints suggestive of neurological problem?**		Yes/No
1	If Yes, have you consulted any doctor for this problem?		Yes/No
2	Neurological Symptoms	**Response**	Duration

3	Increased difficulty in remembering	**Yes/No**	
4	Headache	**Yes/No**	
5	Loss of awareness regarding time, place and person	**Yes/No**	
6	Loss of balance/falls/weakness	**Yes/No**	
7	Involuntary movements of parts of body-tremors/inability to control limbs	**Yes/No**	
8	Pain/altered sensation	**Yes/No**	
9	Any other, specify:		

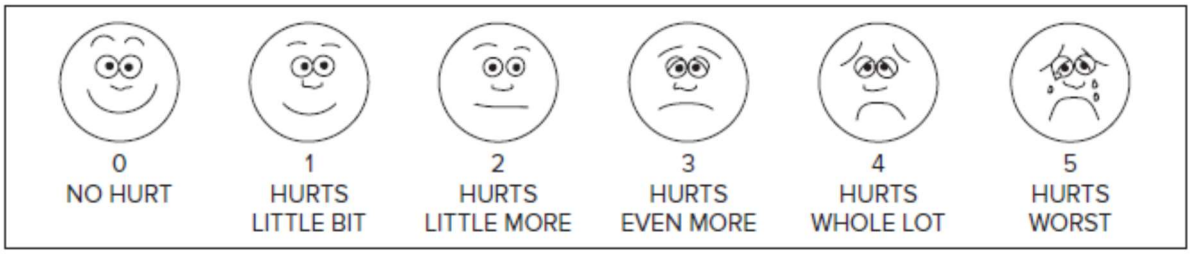
S.No	Complaint / Issues		Response
A-9	**Do you have any complaints related to muscles, bones or joints?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	Musculo-skeletal symptoms	**Response**	**Duration**
3	Pain or stiffness in muscles, joints or back	**Yes/No**	
4	Any swelling in joints?	**Yes/No**	
5	Difficulty in carrying out normal activities	**Yes/No**	
6	Difficulty in walking up and down stairs	**Yes/No**	
7	Any other, specify:		

Tool Commonly used to Rate Pain

Visual Analogue Scale



"Faces" Pain Rating Scale



S.No	Complaint / Issues		Response
A-10	**NOTE: Ask Females Only** **Do you have any gynaecological symptoms?**		**Yes/No**
1	If Yes, have you consulted any doctor for this problem?		**Yes/No**
2	Gynaecological Symptoms	**Response**	**Duration**

3	Bleeding per vagina	**Yes/No**	
4	Discharge per vagina	**Yes/No**	
5	Swelling/mass felt at the genital region	**Yes/No**	
6	Pain in the lower part of the belly	**Yes/No**	
7	Any history of surgical removal of womb (hysterectomy)?	**Yes/No**	
8	Have you ever been screened for: Breast Cancer/SBE/Mammogram Cervical Cancer/VIA-VILI/Colposcopy/PAP SMEAR	**Yes/No**	
9	Any other, specify:		

B - 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, Name 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	
Smoking (Eg. Cigarette, beedi, cigar, hookah)	Y/N		No. Of pieces/ packets	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**
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 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) 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 F1WITH 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	

Nutritional 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 Veg.

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

H a. 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?		

H b. Social and Spiritual assessment

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

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

c) 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

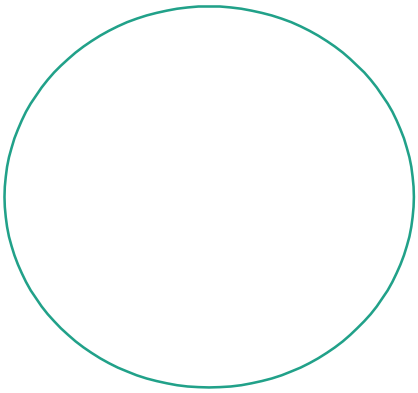
Healthcare worker to assess the following:

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

Section 3: 10-minute Comprehensive Screening

A: 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 at section 5c)	Are you often sad/ depressed?	Yes	No		
FALLS (if yes to first question and not	Fallen more than twice in last 1 year	Yes	No		

able to walk around chair/if unsteady proceed to fall risk assessment toolkit at section 5d)	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 at section 5e)	Lost urine/got wet in past one year/ week?	Yes	No	
*MEMORY RECALL	One object	Two objects	Three objects	None
MiniCog Score				

Scoring for Memory testing:

Three item recall score: 1 point is given for each word recalled without cues, for a 3-item recall score of 1, 2, or 3.

Clock draw score: 2 points are given for a normal clock or 0 (zero) points for an abnormal clock drawing. A normal clock must include all numbers (1-12), each only once, in the correct order and direction (clockwise). There must also be two hands present, one pointing to the 11 and one pointing to 2. Hand length is not scored in the Mini-Cog© algorithm.

Add the 3-item recall and clock drawing scores together. A total score of 3, 4, or 5 indicates lower likelihood of dementia but does not rule out some degree of cognitive impairment.

If the score is <3, consider positive for memory loss and refer to the toolkit for assessment of Memory loss) (Section 5a)

B. 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	

Section C: Functional Assessment:

Assessment tool for Activity of Daily Living

Activities Points (0 or 1)	Independence (1 point) NO supervision, direction or personal assistance	Dependence (0 point) WITH supervision, direction, personal assistance or total care
Bathing	(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
Dressing	(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	(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	(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	(1 POINT) Exercises complete self-control over urination and defecation	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
Feeding	(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)

Section 4: Physical Examination

A: General Examination

1) Height: cm
2) Weight: kg
3) Waist circumference: C ITl
4) Hip circumference: cm
5) Body mass index (BMI) (kg/m2):
6) Waist hip ratio (formula is waist circumference/hip circumference):
7) Temperature (Normal: 98.6°F- 99.6°F)
8) Respiratory rate (Normal: 14-18 breaths/minute)
9) Pulse rate (Normal: 60-100 beats/minute)
10) Blood pressure (in sitting, standing and supine position) (Normal systolic/diastolic: 100-140/60-90 mm Hg)

Supine position: mm of Hg Sitting position: mm of Hg

Head to toe Examination

Aspects to be examined	Findings (tick wherever applicable)
Level of consciousness	Alert-oriented-cooperative
Build	Thin/average/large
Stature	Small/average/tall
Nutrition	Undernourished/average/obese
Facial Appearance	Absence of wrinkling of forehead/deviation of angle mouth
Hair	Loss of hair Colour of hair-white/grey/brownish discolouration
Eyes	Drooping of eyelids Pallor Yellow discolouration (of sclera) Bitot's spots Cataract

Mouth	Dryness of lips Soreness in angle of mouth Dryness of tongue Ulcer in mouth/tongue Presence/absence of teeth Staining of teeth Swelling/bleeding from gums Any growth seen in mouth Pallor/bluish discolouration (of tongue and lips)
Neck	Swelling
Chest	Abnormal shape of chest Fats breathing (respiratory rate, 20/minute)
Abdomen	Distension of abdomen Change in shape of abdomen
Hands and nails	Change in shape of nails, pallor (nails and palms)
Feet and toes	Bow legs/knocked knees/claw foot
Skin	Yellowish discoloration Dryness Any change in colour of skin Any growth on skin
Any obvious deformity (of skull, spine, limbs or swelling of abdomen/feet/face/entire body)	

C - Systemic Examination

	What to look for?	**Description**
Joints	Redness Swelling Degree of movements Increased local temperature Tenderness	
Cervical Spine	Pain Stiffness Tenderness	
Thoracic Spine	Curvature Scars Discolorations	

Lumbar spine RS	Respiratory rate Respiratory rhythm Palpate the following: Size and shape of the thorax during respirations Intercostal spaces (for bulging or retractions) Any scars or other skin abnormalities (skin temperature as well) Tenderness or pain (palpate gently) Breath sounds (normal/abnormal-adventious sounds)			
CVS	Chest Pain S1/S2 Murmurs Palpitation			
P/A	Shape Position of umbilicus Dilated veins			
Neurological examination				
			Right	**Left**
Muscle strength	Upper limb	Shoulder		
		Elbow		
		Wrist		
		Small muscles of hand		
	Lower limb	Hip		
		Knee		
		Ankle		
Tone	Rigidity/Hypotonia/ Spasticity	Describe		
Balance	**Normal/Abnormal**	**Sensory**	**Cerebellar**	**Vestibular**
Gait				
Timed Up and Go test (secs)				

D - Current Treatment Details:

[Document all prescription and nonprescription drugs including over the counter medications and alternative medications]

Drug with dose and schedule	Drug with dose and schedule
1.	2.
3.	4.

5.	6.	
7.	8.	
9.	10.	
Polypharmacy (any use of >4 drugs including over the counter drugs and alternative medicines)	YES	NO

Section 5: Syndrome specific Toolkit for assessment of the problems identified during Section 3.

Section 5	
Purpose	To conduct a detailed assessment of the geriatric syndromes and other problems detected during the initial screening Memory Loss Depression Incontinence Falls
Eligibility to conduct	Medical Officer with nurse (physical therapist, social worker, pharmacist may contribute their sections)
Time taken	30 to 40 minutes

Section 5a: Memory loss evaluation form

Purpose	To evaluate for memory loss
Eligibility to conduct	Medical Officer
Time taken	5 to 15 minutes

Assess history of the memory problem

Obtain relevant psychiatric history

Medication History: Observe if patient is on any benzodiazepines, sedative hypnotic medications, any recent change in medication or health status.

Family History: Tick all that are present

	Dementia		Cardiovascular disease
	Hypertension		Depression
	Stroke		Down's Syndrome
	Diabetes		Parkinson's Disease

Symptoms (Tick positives):

	Speech difficulty		Emotional change
	Delusions		Fall
	Confusion		Injury
	Aggressive		Balance problems
	Hallucinations		Eating problems

List the main problems identified by the caregiver

1. _____
2. _____
3. _____

Section 5b: Screening for cognitive impairment – The GPCOG-General Practitioner Assessment of Cognition

What for?	Screening test for cognitive impairment
By whom?	Medical Officer
How long?	5 minutes

GPCOG Screening Test

Step 1: Patient Examination

Unless specified, each question should only be asked once

S.No		Correct	Incorrect
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			
2	What is the date? (exact only)	Correct	Incorrect
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, e.g. "War", "lot of rain", ask for details. Only specific answer scores).		
Recall			
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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Step 2 of GPCOG: (the informant interview)

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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Section 5c: Screening for Depression – The Geriatric Depression Scale

Purpose	To assess for depression in Older Adults
Eligibility	Medical officer
Duration	5 minutes

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.

Section 5d: Fall risk Evaluation Form

Purpose	To investigate the origin of falls
Eligibility	Medical Officer
Duration	20 minutes

Section 5d: Part 1

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?

Section 5d Part 2: Fall assessment

Timed Up and Go (TUG) Test

Name:_____ MR: _____ Date: _____

Equipment: arm chair, tape measure, tape, stop watch.

1) Begin the test with the subject sitting correctly (hips all of the way to the back of the seat) in a chair with arm rests. The chair should be stable and positioned such that it will not move when the subject moves from sit to stand. The subject is allowed to use the arm rests during the sit – stand and stand – sit movements.
2) Place a piece of tape or other marker on the floor 3 meters away from the chair so that it is easily seen by the subject.
3) Instructions: "On the word GO you will stand up, walk to the line on the floor, turn around and walk back to the chair and sit down. Walk at your regular pace.
4) Start timing on the word "GO" and stop timing when the subject is seated again correctly in the chair with their back resting on the back of the chair.
5) The subject wears their regular footwear, may use any gait aid that they normally use during ambulation, but may not be assisted by another person. There is no time limit. They may stop and rest (but not sit down) if they need to.
6) Normal healthy elderly usually complete the task in ten seconds or less. Very frail or weak elderly with poor mobility may take 2 minutes or more.
7) The subject should be given a practice trial that is not timed before testing.
8) Results correlate with gait speed, balance, functional level, the ability to go out, and can follow change over time.

Normative Reference Values by Age 1	
Age Group	**Time in Seconds (95% Confidence Interval)**
60 – 69 years	8.1 (7.1 – 9.0)
70 – 79 years	9.2 (8.2 – 10.2)
80 – 99 years	11.3 (10.0 – 12.7)

Cut-off Values Predictive of Falls by Group	**Time in Seconds**
Community Dwelling Frail Older Adults 2	> 14 associated with high fall risk

Post-op hip fracture patients at time of discharge	> 24 predictive of falls within 6 months after hip fracture
Frail older adults	> 30 predictive of requiring assistive device for ambulation and being dependent in ADLs

Date	Time	Date	Time	Date	Time	Date	Time

Section 5e: Incontinence Assessment and Management

If Screen positive for Incontinence as per Section 1

Conduct Initial Evaluation

Focused history, targeted examination and evaluation

Identify reversible causes of Incontinence

Develop a management plan/plan of referral to identify and manage the incontinence

The Three Incontinence questions (3IQ)

If reversible causes for urinary incontinence have been identified and managed or ruled out, assess for stress, urge or mixed incontinence using the 3 incontinence questions given below:

1) During the last 3 months, have you leaked urine (even a small amount?) Yes/No
2) During the last 3 months, did you leak urine: (Check all that apply.)
   A) When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?
   B) When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?

3) Without physical activity and without a sense of urgency?
   A) During the last 3 months, did you leak urine most often: (Check only one.)
   B) When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?
   C) When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?

D) Without physical activity and without a sense of urgency?

E) About equally as often with physical activity as with a sense of urgency?

Definitions of type of urinary incontinence are based on response to question 3

Response to question 3	Type of incontinence
a. When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?	Stress only or stress predominant
b. When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?	Urge only or urge predominant
c. Without physical activity and without a sense of urgency?	Other cause only or other predominant
d. About equally as often with physical activity as with a sense of urgency?	Mixed

Refer to Specialist for detailed assessment and management

F. Caregiver & Elderly abuse assessment

Part 1: Caregiver abuse assessment
(to be administered to elderly person's caregiver)

Please answer the following questions as a helper or caregiver:
(fill the name of the elderly person in the blank spaces)

1	Do you sometimes have trouble making control his/her temper of aggression?	**Yes/No**
2	Do you often feel you are being forced to at out of character or do things you feel bad about?	**Yes/No**
3	Do you find it difficult to manage ('s) behaviour?	**Yes/No**
4	Do you sometimes feel that you are forced to be rough with?	**Yes/No**
5	Do you sometimes feel you cant do what is really necessary or what should be done for?	**Yes/No**
6	Do you often feel you have to reject or ignore?	**Yes/No**
7	Do you often feel so tired and exhausted that you cannot control meet ('s) needs?	**Yes/No**
8	Do you often feel you have to yell at?	**Yes/No**
Total Score		

A score of even 1 is indicative of abuse and a score greater than 4 is suggestive of a higher risk of being abused.

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 findings 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

Section 6: Comprehensive Geriatric Assessment Report

Acute Illness	
Comorbidity	
Geriatric Giants/Syndromes	

Other age-related problem	
Social problems	
Economic problems	
Suggested Prescription modification	
ADVICE/CARE PLAN	

Assessing Doctor: _____

Name of Hospital / Clinic: _____

Date of Assessment: _____ Signature of Doctor: _____