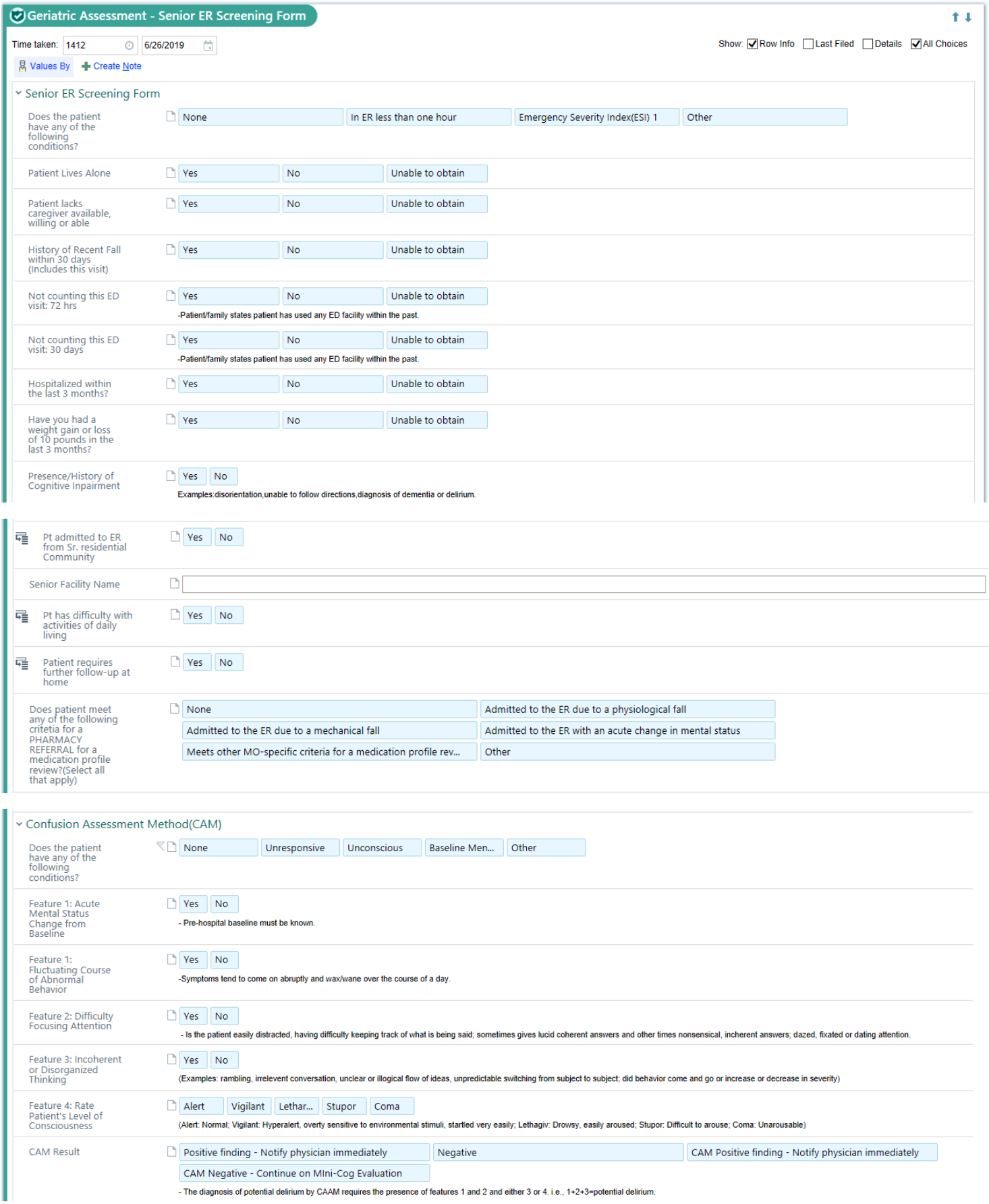
EPIC Geriatric Assessment – Senior ER Screening Form

Dallas Regional Medical Center



Geriatric Assessment - Senior ER Screening Form

Time taken: 1412 6/26/2019

Show: ☑ Row Info ☐ Last Filed ☐ Details ☑ All Choices

Values By | Create Note

Senior ER Screening Form

Does the patient have any of the following conditions?	None	In ER less than one hour	Emergency Severity Index(ESI) 1	Other
Patient Lives Alone	Yes	No	Unable to obtain	
Patient lacks caregiver available, willing or able	Yes	No	Unable to obtain	
History of Recent Fall within 30 days (Includes this visit)	Yes	No	Unable to obtain	
Not counting this ED visit: 72 hrs	Yes	No	Unable to obtain	
	-Patient/family states patient has used any ED facility within the past.			
Not counting this ED visit: 30 days	Yes	No	Unable to obtain	
	-Patient/family states patient has used any ED facility within the past.			
Hospitalized within the last 3 months?	Yes	No	Unable to obtain	
Have you had a weight gain or loss of 10 pounds in the last 3 months?	Yes	No	Unable to obtain	
Presence/History of Cognitive Inpairment	Yes	No		
	Examples:disorientation,unable to follow directions,diagnosis of dementia or delirium.			

Pt admitted to ER from Sr. residential Community	Yes	No
Senior Facility Name		
Pt has difficulty with activities of daily living	Yes	No
Patient requires further follow-up at home	Yes	No
Does patient meet any of the following critetia for a PHARMACY REFERRAL for a medication profile review?(Select all that apply)	None	Admitted to the ER due to a physiological fall
	Admitted to the ER due to a mechanical fall	Admitted to the ER with an acute change in mental status
	Meets other MO-specific criteria for a medication profile rev...	Other

Confusion Assessment Method(CAM)

Does the patient have any of the following conditions?	None	Unresponsive	Unconscious	Baseline Men...	Other
Feature 1: Acute Mental Status Change from Baseline	Yes	No			
	- Pre-hospital baseline must be known.				
Feature 1: Fluctuating Course of Abnormal Behavior	Yes	No			
	-Symptoms tend to come on abruptly and wax/wane over the course of a day.				
Feature 2: Difficulty Focusing Attention	Yes	No			
	- Is the patient easily distracted, having difficulty keeping track of what is being said; sometimes gives lucid coherent answers and other times nonsensical, incherent answers; dazed, fixated or dating attention.				
Feature 3: Incoherent or Disorganized Thinking	Yes	No			
	(Examples: rambling, irrelevent conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject; did behavior come and go or increase or decrease in severity)				
Feature 4: Rate Patient's Level of Consciousness	Alert	Vigilant	Lethar...	Stupor	Coma
	(Alert: Normal; Vigilant: Hyperalert, overty sensitive to environmental stimuli, startled very easily; Lethagiv: Drowsy, easily aroused; Stupor: Difficult to arouse; Coma: Unarousable)				
CAM Result	Positive finding - Notify physician immediately	Negative	CAM Positive finding - Notify physician immediately	CAM Negative - Continue on MIni-Cog Evaluation	
	- The diagnosis of potential delirium by CAAM requires the presence of features 1 and 2 and either 3 or 4. i.e., 1+2+3=potential delirium.				

Mini-Cog Assessment

Does this patient have any of the following conditions?

- [ ] None
- [ ] Dementia/Alzheimer's
- [ ] Delirum
- [ ] Behavioral issues/Suicidal
- [ ] Adverse drug effects/Sedated
- [ ] Positive for alcohol
- [ ] Language barriers
- [ ] Patient declines
- [ ] Comfort Measure/Palliative Care
- [ ] Physical/Visual impairment
- [ ] Admitted from Long Term Care Facility
- [ ] MIni Cog within 30 days
- [ ] Unable to complete
- [ ] Other

Document three words given to patient

- [ ] Cup
- [ ] Train
- [ ] Blue

The test is administered as follows: Please listen carefully, I am going to tell you three unrelated words. I want you to remember the words and repeat them to me (the nurse may repeat the same three words up to three times to the patient if necessary)

Did the clock drawn by the patient include all numbers in the correct sequence and position AND do the hands readably display the time 11:10? Length of hands is not considered in the scoring.

- [ ] Yes
- [ ] No

Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet of paper that already has the clock circle drawn. After the patient puts the numbers on the clock face, ask to draw the hands of the clock to read 11:10.

Number of words correctly recalled

- [ ] O words
- [ ] 1.2 words
- [ ] 3 words

Ask the patient to recall and state the three words given to him at the beginning of the test.

Mini-Cog Result

- [ ] Demented
- [ ] Non-Demented

Interpretation of Results:

- [ ] Patient screening results - demented, notify physician immediately
- [ ] Patient screening results - not demented, continue with GDS Evalustion

0-2: Positive screen for dementia
3-5: Negative screen for dementia

Scoring: (Out of total of 5 points)

- [ ] 0
- [ ] 1
- [ ] 2
- [ ] 3

Give 1 point for each recalled word after the Clock Drawing Test (CDT) distractor. Recall is scored 0-3.
The CDT distractor is scored 2 if normal and 0 if abnormal.

Geriatric Depression Scale (GDS-5)

Does this patient have any of the following conditions?

- [ ] None
- [ ] Emergency severity index (ESI) 1
- [ ] In ER less than one hour
- [ ] Dementia/Alzheimer's
- [ ] Delirum
- [ ] Behavioral issues/Suicidal
- [ ] Adverse drug effects/Sedated
- [ ] Positive for alcohol
- [ ] Patient declines
- [ ] Comfort Measure/Palliative Care
- [ ] Admit within 30 days
- [ ] Unable to articulate
- [ ] Admitted from Long Term C...
- [ ] Unable to complete
- [ ] Other

Are you basically satisfied with your life?

- [ ] 1=Yes
- [ ] 0=No

Do you often get bored?

- [ ] 1=Yes
- [ ] 0=No

Do you often feel helpless?

- [ ] 1=Yes
- [ ] 0=No

Do you prefer to stay at home, rather than going out and doing new things?

- [ ] 1=Yes
- [ ] 0=No

Do you feel pretty worthless the way you are now?

- [ ] 1=Yes
- [ ] 0=No

GDS TOTAL Score

A Score of greater than or equal to 2 points is suggestive of ?

- [ ] Indicates possible depression
- [ ] Not indicative of depression
- [ ] Possible depression continue with screening
- [ ] Patient is not depressed

Self Harm Risk Screen - "As I ask these questions, think about the past month".

Have you ever wished you could go to sleep and not wake up?	Yes	No	Unable to obtain
Have you had thoughts of killing yourself?	Yes	No	Unable to obtain
Have you been thinking about how you might do this?	Yes	No	Unable to obtain
Are you intending to act on these thoughts?	Yes	No	Unable to obtain
Have you started working out details on how to kill yourself?	Yes	No	Unable to obtain
Have you ever done anything, started to do anything, or prepared to do anything to end your life/	Yes	No	Unable to obtain
How long ago did you do any of these?	Within the last three months	Between three months and a year ago	Over one year ago
Comments/Details of Past Suicidal Behavior/Ideation			

Note changes from Previous Screen

Clinician/Family believes suicidal intent/behavior may exist	Yes	No

Senior ER Screening Summary

Presence/History of Cognitive Impairment	Yes	No
Confusion Assessment Method Finding	Positive finding - Notify physician immediately	Negative
Mini-Cog Assessment Finding	Demented	Non-Demented
Geriatric Depression Scale-5 Finding	Indicates possible depression	Not indicates of depression
Self Harm Screening Result	Positive	Negitive
Pharmacy Referral Finding	Positive	Negative
Additional Nursing Generated Referrals	Yes	No

Restore | Close | Cancel | Previous | Next