

HUD's Integrated Wellness in Supportive Housing (IWISH)
Resident and Wellness Assessment –
Paper Version - **DRAFT**

PAPERWORK REDUCTION ACT STATEMENT OF PUBLIC BURDEN:

The public reporting burden for this information collection is estimated to be 80 minutes. This burden estimate includes time for reviewing instructions, researching existing data sources, gathering and maintaining the needed data, and completing and submitting the information. Send comments regarding the accuracy of this burden estimate and any suggestions for reducing the burden to: U.S. Office of Personnel Management, Federal Investigative Services, Attn: OMB Number (3206-0246), 1900 E Street NW, Washington, DC 20415-7900.

The information requested under this collection is protected and held confidential in accordance with 42 U.S.C. 1306, 20 CFR 401 and 402, 5 U.S.C.552 (Freedom of Information Act), 5 U.S.C. 552a (Privacy Act of 1974) and OMB Circular No. A-130.

Please use this paper version of the health and wellness assessment for times when you cannot enter information directly into the demonstration's online platform, hosted by Population Health Logistics (PHL). After completing the paper assessment, please follow the IWISH PHL User Guide for instructions on how to enter the data into PHL.

Participant Information	
1. First Name	
2. Middle Name	
3. Last Name	
4. Date of Birth	
5. Gender (select one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Does Not Declare <input type="checkbox"/> Other
6. Preferred Language (select one)	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Albanian <input type="checkbox"/> Arabic <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese-Cantonese <input type="checkbox"/> Chinese –Mandarin <input type="checkbox"/> Farsi <input type="checkbox"/> French Creole <input type="checkbox"/> German <input type="checkbox"/> Greek <input type="checkbox"/> Hindi <input type="checkbox"/> Italian <input type="checkbox"/> Korean <input type="checkbox"/> Persian <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Tagalog <input type="checkbox"/> Twi <input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____
7. Date(s) of Assessment	

8. Marital Status (select one)	<input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other _____
9. Race/Ethnicity (select all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____
10. Social Security Number	_____ - _____ - _____
11. Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Was the Participant Information section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

Participant Contact Information

Add Address

1. Address Type Home Mailing Other

2. Address 1

3. Address 2

4. City, State, Zip

5. Primary Address Yes No

Add Phone

6. Phone Number Type Home Mobile Work Other

7. Phone Number

_____ - _____ - _____

8. Primary Phone

Yes
 No

Add Email

9. Email Type (select one) Personal Family Member Email Address
 Other

10. Email Address

11. Primary Email

Yes
 No

12. Was the Participant Contact Information section completed in full?

Yes – section completed in full
 No – not yet completed
 No – participant refused to answer one or more questions

Insurance

*Ability to add multiple insurance policies. Space for two is included below.

1. Insurance Number	
2. Insurance Type (select one)	<input type="checkbox"/> Medicare Part A (Hospital Coverage) <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part C (Medicare Advantage) <input type="checkbox"/> Medicare Part D (Prescription Coverage) <input type="checkbox"/> Medicare Supplemental (Medigap) <input type="checkbox"/> Medicaid <input type="checkbox"/> PACE <input type="checkbox"/> Tricare <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Commercial Insurance <input type="checkbox"/> Uninsured <input type="checkbox"/> Other
3. Insurance Number	
4. Insurance Type (select one)	<input type="checkbox"/> Medicare Part A (Hospital Coverage) <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part C (Medicare Advantage) <input type="checkbox"/> Medicare Part D (Prescription Coverage) <input type="checkbox"/> Medicare Supplemental (Medigap) <input type="checkbox"/> Medicaid <input type="checkbox"/> PACE <input type="checkbox"/> Tricare <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Commercial Insurance <input type="checkbox"/> Uninsured <input type="checkbox"/> Other

5. Insurance Number	
6. Insurance Type (select one)	<input type="checkbox"/> Medicare Part A (Hospital Coverage) <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part C (Medicare Advantage) <input type="checkbox"/> Medicare Part D (Prescription Coverage) <input type="checkbox"/> Medicare Supplemental (Medigap) <input type="checkbox"/> Medicaid <input type="checkbox"/> PACE <input type="checkbox"/> Tricare <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> Commercial Insurance <input type="checkbox"/> Uninsured <input type="checkbox"/> Other
7. Was the Insurance section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

Contacts

*Ability to add multiple contacts. Space for three contacts is included below.

Contact Details – Contact #1

1. Full Name (of contact)			
2. Relationship to Participant (select one)	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Daughter-in-law <input type="checkbox"/> Son-in-law <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Spouse Equivalent <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Granddaughter <input type="checkbox"/> Grandson <input type="checkbox"/> Nephew <input type="checkbox"/> Niece <input type="checkbox"/> Other		
3. Power of Attorney (POA) (select one)	<input type="checkbox"/> Health Care <input type="checkbox"/> Financial <input type="checkbox"/> Health Care and Financial <input type="checkbox"/> Not Applicable		
4. Guardian (select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	5. Contact Method Preference (select one)	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Phone or Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other

6. Frequency of participant meeting with this contact (select one)	<input type="checkbox"/> Daily	<input type="checkbox"/> 2-3 times weekly	<input type="checkbox"/> Weekly	<input type="checkbox"/> 2-3 times/month	<input type="checkbox"/> Several times/year	<input type="checkbox"/> As-needed	<input type="checkbox"/> Other
7. Primary Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Emergency Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
9. Caregiver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. Household (i.e., does this contact live in participant's home?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
11. Address Type	<input type="checkbox"/> Home	<input type="checkbox"/> Other	12. Primary Address	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
13. Address							
14. City, State, Zip							
15. Phone Number Type	<input type="checkbox"/> Home	<input type="checkbox"/> Mobile	16. Phone Number	_____ - _____ - _____			
	<input type="checkbox"/> Work	<input type="checkbox"/> Other		Ext: (_____)			
17. Primary Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
18. Email Type (select one)	<input type="checkbox"/> Personal	<input type="checkbox"/> Family Member	19. Primary Email	<input type="checkbox"/> Yes			
	<input type="checkbox"/> Office	<input type="checkbox"/> Other		<input type="checkbox"/> No			

20. Email Address	
Contact Details – Contact #2 (if applicable)	
1. Full Name (of contact)	
2. Relationship to Participant (select one)	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Daughter-in-law <input type="checkbox"/> Son-in-law <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Spouse Equivalent <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Granddaughter <input type="checkbox"/> Grandson <input type="checkbox"/> Nephew <input type="checkbox"/> Niece <input type="checkbox"/> Other
3. Power of Attorney (POA) (select one)	<input type="checkbox"/> Health Care <input type="checkbox"/> Financial <input type="checkbox"/> Health Care and Financial <input type="checkbox"/> Not Applicable
4. Guardian (select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
5. Contact Method Preference (select one)	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Phone or Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other
6. Frequency of participant meeting with this contact (select one)	<input type="checkbox"/> Daily <input type="checkbox"/> 2-3 times weekly <input type="checkbox"/> Weekly <input type="checkbox"/> 2-3 times/month <input type="checkbox"/> Several times/year <input type="checkbox"/> As-needed <input type="checkbox"/> Other

7. Primary (i.e., primary contact)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Emergency Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Caregiver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. Household (i.e., does this contact live in participant's home?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Address Type	<input type="checkbox"/> Home	<input type="checkbox"/> Other	12. Primary Address	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Address					
14. City, State, Zip					
15. Phone Number Type	<input type="checkbox"/> Home	<input type="checkbox"/> Mobile	16. Phone Number	_____-_____-_____	
	<input type="checkbox"/> Work	<input type="checkbox"/> Other		Ext: (_____)	
17. Primary Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
18. Email Type (select one)	<input type="checkbox"/> Personal		19. Primary Email	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Family Member				
	<input type="checkbox"/> Office				
	<input type="checkbox"/> Other				

20. Email Address	
Contact Details – Contact #3 (if applicable)	
1. Full Name (of contact)	
2. Relationship to Participant (select one)	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Daughter-in-law <input type="checkbox"/> Son-in-law <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Spouse Equivalent <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Granddaughter <input type="checkbox"/> Grandson <input type="checkbox"/> Nephew <input type="checkbox"/> Niece <input type="checkbox"/> Other
3. Power of Attorney (POA) (select one)	<input type="checkbox"/> Health Care <input type="checkbox"/> Financial <input type="checkbox"/> Health Care and Financial <input type="checkbox"/> Not Applicable
4. Guardian (select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
5. Contact Method Preference (select one)	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Phone or Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other
6. Frequency of participant meeting with this contact (select one)	<input type="checkbox"/> Daily times/month <input type="checkbox"/> 2-3 times weekly <input type="checkbox"/> Weekly <input type="checkbox"/> 2-3 <input type="checkbox"/> Several times/year <input type="checkbox"/> As-needed <input type="checkbox"/> Other

7. Primary (i.e., primary contact)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Emergency Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Caregiver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. Household (i.e., does this contact live in participant's home?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Address Type	<input type="checkbox"/> Home	<input type="checkbox"/> Other	12. Primary Address	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Address					
14. City, State, Zip					
15. Phone Number Type	<input type="checkbox"/> Home	<input type="checkbox"/> Mobile	16. Phone Number	____-____-____ Ext: (____)	
	<input type="checkbox"/> Work	<input type="checkbox"/> Other			
17. Primary Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
18. Email Type (select one)	<input type="checkbox"/> Personal		19. Primary Email	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Family Member				
	<input type="checkbox"/> Office	<input type="checkbox"/> Other			
20. Email Address					

- | | |
|---|--|
| 21. Was the Contacts section completed in full? | <input type="checkbox"/> Yes – section completed in full
<input type="checkbox"/> No – not yet completed
<input type="checkbox"/> No – participant refused to answer one or more questions |
|---|--|

DRAFT

Participant Resources

Specify which resources/services the participant currently receives in this section.

Please use one row for each service and specify the Agency Type, the Category of Service Provided, the Type of Service, Date Service Began, and Current Service Status.

A table listing the different types of services for each category is available following this section.

Service Number	Agency Type	Service Category	Service Type	Date Service Began	Service Status
	<i>Indicate one:</i> <ul style="list-style-type: none"> • Your own IWISH site • Adult Day Care • Area Agency on Aging • Home Health Agency • Mental Health Agency • Primary Care • Specialty Care • Transportation Agency • Other 	<i>Indicate one:</i> <ul style="list-style-type: none"> • Case Management Services • Food • Housing • Home Modification • Utility Assistance • Transportation • Medical • Financial • Legal • Employment • Education • Other 	<i>See choices following this table</i>	<i>If known</i>	<i>Indicate one:</i> <ul style="list-style-type: none"> • Currently Received • Denied • Pending • Waitlisted • Other
1.					
2.					
3.					
4.					

Service Number	Agency Type	Service Category	Service Type	Date Service Began	Service Status
	<i>Indicate one:</i> <ul style="list-style-type: none"> • Your own IWISH site • Adult Day Care • Area Agency on Aging • Home Health Agency • Mental Health Agency • Primary Care • Specialty Care • Transportation Agency • Other 	<i>Indicate one:</i> <ul style="list-style-type: none"> • Case Management Services • Food • Housing • Home Modification • Utility Assistance • Transportation • Medical • Financial • Legal • Employment • Education • Other 	<i>See choices following this table</i>	<i>If known</i>	<i>Indicate one:</i> <ul style="list-style-type: none"> • Currently Received • Denied • Pending • Waitlisted • Other
5.					
6.					
7.					
8.					
9.					
10.					

11. Was the Resources section completed in full?	<input type="checkbox"/> Yes - section completed in full <input type="checkbox"/> No - not yet completed <input type="checkbox"/> No - participant refused to answer one or more questions
--	--

Participant Resources: Category of Services and Associated Type of Service

Please use this table as a reference when completing the *Participant Resource* portion that precedes this section. This table defines the types of services within each service category.

Category of Service	Type of Service
Case Management Services	<input type="checkbox"/> Case management <input type="checkbox"/> Homemaker services <input type="checkbox"/> Level of care assessment <input type="checkbox"/> Options/benefits counseling <input type="checkbox"/> Personal care services <input type="checkbox"/> Other case management services
Food	<input type="checkbox"/> Home delivered meals <input type="checkbox"/> Congregate meals <input type="checkbox"/> SNAP (food stamps) <input type="checkbox"/> Pantry/food bank <input type="checkbox"/> Nutrition education <input type="checkbox"/> Other food/nutrition
Housing	<input type="checkbox"/> Hoarding <input type="checkbox"/> Lease compliance <input type="checkbox"/> Other housing services
Home Modification	<input type="checkbox"/> Home safety assessment <input type="checkbox"/> Accessibility modifications <input type="checkbox"/> Other home modification
Utility Assistance	<input type="checkbox"/> Low Income Home Energy Assistance Program (LIHEAP) <input type="checkbox"/> Other utility assistance
Transportation	<input type="checkbox"/> Transportation voucher/ride program <input type="checkbox"/> Medical transportation <input type="checkbox"/> Driver Safety <input type="checkbox"/> Other transportation
Medical	<input type="checkbox"/> Alcohol use <input type="checkbox"/> Chronic condition management <input type="checkbox"/> Cognitive health <input type="checkbox"/> Dental <input type="checkbox"/> Emergency room use <input type="checkbox"/> Exercise/ physical activity <input type="checkbox"/> Falls <input type="checkbox"/> Financial assistance <input type="checkbox"/> Hearing <input type="checkbox"/> Hospice/ palliative care

Participant Resources: Category of Services and Associated Type of Service

Please use this table as a reference when completing the *Participant Resource* portion that precedes this section. This table defines the types of services within each service category.

Category of Service	Type of Service
	<input type="checkbox"/> Immunizations/ screenings <input type="checkbox"/> Medications <input type="checkbox"/> Medical supplies/ equipment <input type="checkbox"/> Mental health <input type="checkbox"/> Pain Management <input type="checkbox"/> Provider/ pharmacy access and relationships <input type="checkbox"/> Therapy (occupational, physical, speech) <input type="checkbox"/> Tobacco cessation support <input type="checkbox"/> Visual <input type="checkbox"/> Weight management <input type="checkbox"/> Other medical
Financial	<input type="checkbox"/> Budgeting/ financial planning <input type="checkbox"/> Income/benefits <input type="checkbox"/> Insurance <input type="checkbox"/> Other financial
Legal	<input type="checkbox"/> Adult protective services <input type="checkbox"/> End of life planning (will, advance directive, DNR, etc.) <input type="checkbox"/> Guardian <input type="checkbox"/> Power of attorney (financial, medical) <input type="checkbox"/> Other legal
Employment	<input type="checkbox"/> Full/part-time employment <input type="checkbox"/> Senior employment program <input type="checkbox"/> Other employment services
Education	<input type="checkbox"/> Language <input type="checkbox"/> Literacy <input type="checkbox"/> Lifelong learning <input type="checkbox"/> Other education
Other	<input type="checkbox"/> Caregiver support <input type="checkbox"/> Interpersonal relationships (family, friends) <input type="checkbox"/> Pets (care, support/needs) <input type="checkbox"/> Recreation/ social activities <input type="checkbox"/> Spirituality/ religious participation <input type="checkbox"/> Support groups <input type="checkbox"/> Volunteering/ community service <input type="checkbox"/> Other social support or engagement

Immunizations			
Immunization	Status (select one)	Approximate Immunization Date	Notes
1. Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No - Medical Reason		
2. Pneumovax	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No - Medical Reason		
3. Prevnar	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No - Medical Reason		
4. Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No - Medical Reason		
5. Other: _____ —	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No - Medical Reason		
6. Other: _____ —	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No - Medical Reason		
7. Other: _____ —	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No - Medical Reason		
8. Other: _____ —	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No – Medical Reason		
9. Was the Immunization section completed in full?		<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions	

DRAFT

<u>General Information</u>	
Advance Directive, DNR, and POAs	
1. Does participant have a documented Advance Directive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2. If no, would the participant like assistance creating an Advance Directive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Now <input type="checkbox"/> N/A
3. Advance Directive Agent's Name and Contact Information	
4. Where is Advance Directive stored? (select all that apply)	<input type="checkbox"/> Family Member <input type="checkbox"/> Home <input type="checkbox"/> MD Office <input type="checkbox"/> Preferred Hospital <input type="checkbox"/> Other <input type="checkbox"/> N/A
5. Does the participant have a Do Not Resuscitate (DNR) order?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
6. Who, if anyone, has a copy of the participant's DNR?	<input type="checkbox"/> Family Member <input type="checkbox"/> MD Office <input type="checkbox"/> Healthcare Power of Attorney <input type="checkbox"/> Preferred Hospital <input type="checkbox"/> Other <input type="checkbox"/> N/A
7. Does the participant have a Health Care Power of Attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

8. Contact information for who, if anyone, has a copy of the participant's Health Care Power of Attorney?	
9. Does the participant have a Financial Power of Attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
10. Contact information for who, if anyone, has a copy of the participant's Financial Power of Attorney?	
Household, Assistive Devices, and Transportation	
11. Does the participant have a Personal Emergency Response System (PERS) such as Lifeline or Link to Life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Mode(s) of Transportation (select all that apply)	<input type="checkbox"/> Own Car <input type="checkbox"/> Bus <input type="checkbox"/> Support Person <input type="checkbox"/> Transportation Agency <input type="checkbox"/> Other

13. Notes for the General Information Section:

14. Was the General Information section completed in full?

- Yes – section completed in full
- No – not yet completed
- No – participant refused to answer one or more questions

Clinicians

Please include the participant's Primary Care Provider and key specialists the participant regularly visits.

Primary Care Provider

1. Primary Care Provider's full name

2. Phone

____ - ____ - _____

3. Fax

____ - ____ - _____

4. Email

5. Practice Name and Address

Specialist #1

1. Specialist Full Name

2. Specialty
(select one)

Oncologist

Neurologist

Psychologist

Psychiatrist

Cardiologist

Ophthalmologist/Optomtrist

OBGYN

Other _____

3. Phone

____ - ____ - _____

4. Fax

____ - ____ - _____

5. Email

6. Practice Name and Address	
Specialist #2	
1. Specialist Full Name	
2. Specialty (select one)	<input type="checkbox"/> Oncologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Ophthalmologist/Optometrlist <input type="checkbox"/> OBGYN <input type="checkbox"/> Other _____
3. Phone	_____ - _____ - _____
4. Fax	_____ - _____ - _____
5. Email	
6. Address	

Specialist #3	
1. Specialist Full Name	
2. Specialty (select one)	<input type="checkbox"/> Oncologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Ophthalmologist/Optomtrist <input type="checkbox"/> OBGYN <input type="checkbox"/> Other _____
3. Phone	_____ - _____ - _____
4. Fax	_____ - _____ - _____
5. Email	
6. Practice Name and Address	
7. Clinician and Specialist Notes:	
8. Was the Clinician section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

General Health Assessment

Annual Exams, Hospitals, and Surgery

1. How do you rate your health?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good
	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Unknown
2. Do you have routine annual exams?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3. When was your last annual exam, if known?			
4. Have you had surgery in the past 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
5. List all surgical procedures in the past 10 years			

Specific Health Questions

6. Do you use an assistive device to help you move?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Select all assistive device(s) that apply	<input type="checkbox"/> Cane <input type="checkbox"/> Walker	<input type="checkbox"/> Motorized Scooter <input type="checkbox"/> Wheelchair
8. Do you need assistance obtaining any of the following (select all that apply)?	<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Dentures <input type="checkbox"/> Other	<input type="checkbox"/> Hearing aids <input type="checkbox"/> None
9. Does you take care of your own feet/toenails?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

10. If you do not take care of your own feet/toenails, who does?	
11. Do you have any foot conditions (select all that apply)	<input type="checkbox"/> Calluses <input type="checkbox"/> Corns <input type="checkbox"/> Cuts <input type="checkbox"/> Bruises <input type="checkbox"/> Fungus <input type="checkbox"/> Overgrown Toenails <input type="checkbox"/> Ingrown Toenails <input type="checkbox"/> Dry Skin <input type="checkbox"/> N/A <input type="checkbox"/> Other
12. How many days a week do you get a total of 30 minutes or more of physical activity? (enough to raise breathing rate) (select one)	<input type="checkbox"/> Zero <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five <input type="checkbox"/> Six <input type="checkbox"/> Seven
13. Was the General Health Assessment section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

DRAFT

Diagnosis

Diagnosis (select all that apply)		Notes
1. Heart/ Circulation	<input type="checkbox"/> Cancer <input type="checkbox"/> Anemia <input type="checkbox"/> Atrial Fibrillation or other Dysrhythmias (bradycardias and tachycardia) <input type="checkbox"/> Coronary Artery Disease (angina, myocardial infarction, atherosclerotic heart disease) <input type="checkbox"/> Deep Vein Thrombosis <input type="checkbox"/> Pulmonary Embolus <input type="checkbox"/> Pulmonary Edema <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Pre-Hypertension <input type="checkbox"/> Hypertension <input type="checkbox"/> Pacemaker/ Implantable Cardiac Defibrillator	

2. Gastrointestinal	<ul style="list-style-type: none"><input type="checkbox"/> Cirrhosis<input type="checkbox"/> Ulcer (esophageal, gastric, and peptic ulcers)<input type="checkbox"/> GERD or Acid Reflux<input type="checkbox"/> Diverticulitis<input type="checkbox"/> Liver Disease<input type="checkbox"/> Crohn's Disease<input type="checkbox"/> Irritable Bowel Syndrome	
3. Genitourinary	<ul style="list-style-type: none"><input type="checkbox"/> Benign Prostatic Hyperplasia<input type="checkbox"/> Renal Insufficiency<input type="checkbox"/> Renal Failure<input type="checkbox"/> End Stage Renal Disease<input type="checkbox"/> Neurological Bladder<input type="checkbox"/> Obstructive Uropathy	

4. Infections	<input type="checkbox"/> Multi-drug resistant organisms <input type="checkbox"/> Pneumonia <input type="checkbox"/> Septicemia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Viral Hepatitis <input type="checkbox"/> Wound Infection (other than foot)	
5. Metabolic and Endocrine	<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Hyponatremia <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Thyroid Disease	
6. Musculoskeletal	<input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Hip Fracture <input type="checkbox"/> Other Fracture	

7. Neurological

- Alzheimer's Disease
- Aphasia
- Cerebral Palsy
- Cerebrovascular Accident
- Transient Ischemic Attack
- Stroke
- Non-Alzheimer's Dementia
- Hemiplegia
- Hemiparesis
- Paraplegia
- Quadriplegia
- Multiple Sclerosis
- Huntington's Disease
- Parkinson's Disease
- Tourette's Syndrome
- Seizure Disorder
- Epilepsy
- Traumatic Brain Injury

8. Nutritional	<input type="checkbox"/> Malnutrition <input type="checkbox"/> Risk for Malnutrition	
9. Psychiatric Mood Disorders	<input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Manic Depression (bipolar) <input type="checkbox"/> Psychotic Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Post-Traumatic Stress Disorder	
10. Addiction	<input type="checkbox"/> Nicotine <input type="checkbox"/> Alcohol Abuse	
11. Sleep Disorder	<input type="checkbox"/> Insomnia <input type="checkbox"/> Sleep Apnea	
12. Pulmonary	<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive Pulmonary Disorder <input type="checkbox"/> Chronic Lung Disease (chronic bronchitis and restrictive lung diseases such as asbestosis) <input type="checkbox"/> Respiratory Failure	

13. Hearing	<input type="checkbox"/> Hearing Impairment	
14. Vision	<input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> General Visual Decline	
15. Other	<input type="checkbox"/> Chronic Pain <input type="checkbox"/> Obesity <input type="checkbox"/> Other	
16. Was the Diagnosis section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions	

Medication

Medication Name	Strength (i.e. dosage)	Units	Dosage Frequency	Dosage Number	Dosage Method	Special Instructions

1. Was the Medication section completed in full?			<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions			

Medication Review

Medication #1 (enter name of medication):

<p>1. Medication Review Prescription Status (select all that apply)</p>	<p><input type="checkbox"/> New taken < 1 week</p> <p><input type="checkbox"/> Ongoing</p> <p><input type="checkbox"/> Review requested</p> <p><input type="checkbox"/> Discontinued</p> <p><input type="checkbox"/> Prescription not filled</p> <p><input type="checkbox"/> Refill overdue</p> <p><input type="checkbox"/> Other</p>
<p>2. Why are you taking this medication?</p>	
<p>3. Does the participant seem to understand why they are taking this medication?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>
<p>4. Are you able to read the prescription label?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>
<p>5. How do you take this medication? (select all that apply)</p>	<p><input type="checkbox"/> Self (i.e., the participant)</p> <p><input type="checkbox"/> Caregiver</p> <p><input type="checkbox"/> RN</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other</p>

<p>6. Where do you store this medication? (select one)</p>	<input type="checkbox"/> Bag <input type="checkbox"/> Bathroom cabinet <input type="checkbox"/> Refrigerator <input type="checkbox"/> Bathroom counter <input type="checkbox"/> Box <input type="checkbox"/> Kitchen cabinet <input type="checkbox"/> Kitchen counter <input type="checkbox"/> Mixed containers <input type="checkbox"/> Multiple locations <input type="checkbox"/> Night stand <input type="checkbox"/> Other
<p>7. Would you like to consider an alternative medication, if available? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>8. Would you like to speak with your doctor or pharmacist about this medication? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>9. Does this participant share their medication with anyone? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>10. After reviewing all of this participant's medications, is an additional medication review or medication reconciliation recommended? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>Medication #2 (enter name of medication): _____</p>	

<p>1. Medication Review Prescription Status (select all that apply)</p>	<p><input type="checkbox"/> New taken < 1 week <input type="checkbox"/> Ongoing <input type="checkbox"/> Review requested <input type="checkbox"/> Discontinued <input type="checkbox"/> Prescription not filled <input type="checkbox"/> Refill overdue <input type="checkbox"/> Other</p>
<p>2. Why are you taking this medication?</p>	
<p>3. Does this participant seem to understand why they are taking this medication?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>
<p>4. Are you able to read the prescription label?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>
<p>5. How do you take this medication? (select all that apply)</p>	<p><input type="checkbox"/> Self (i.e., the participant) <input type="checkbox"/> Caregiver <input type="checkbox"/> RN <input type="checkbox"/> Unknown <input type="checkbox"/> Other</p>

<p>6. Where do you store this medication? (select one)</p>	<input type="checkbox"/> Bag <input type="checkbox"/> Bathroom cabinet <input type="checkbox"/> Refrigerator <input type="checkbox"/> Bathroom counter <input type="checkbox"/> Box <input type="checkbox"/> Kitchen cabinet <input type="checkbox"/> Kitchen counter <input type="checkbox"/> Mixed containers <input type="checkbox"/> Multiple locations <input type="checkbox"/> Night stand <input type="checkbox"/> Other
<p>7. Would this participant like to consider an alternative medication if available? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>8. Would this participant like to speak with the prescribing clinician or pharmacist about this medication? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>9. Does this participant share their medication with anyone? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>10. After reviewing all of this participant's medications, is an additional medication review or medication reconciliation recommended? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

1. Was the Medication Review section completed in full?

- Yes – section completed in full
- No – not yet completed
- No – participant refused to answer one or more questions

Supplemental Medication Review sheets are available at the end of this Assessment for printing when necessary.

Morisky 8-Item Medication Adherence Questionnaire

Question	Patient Answer
1. Do you sometimes forget to take your medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. People sometimes miss taking their medicines for reasons other than forgetting. Thinking over the past two weeks, were there any days when you did not take your medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever cut back or stopped taking your medicine without telling your doctor because you felt worse when you took it?	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. When you travel or leave home, do you sometimes forget to bring along your medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Did you take all your medicines yesterday?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. When you feel like your symptoms are under control, do you sometimes stop taking your medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Taking medicine every day is a real inconvenience for some people. Do you ever feel hassled about sticking to your treatment plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. How often do you have difficulty remembering to take all your medicine?	<input type="checkbox"/> Never/rarely <input type="checkbox"/> Once in a while <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> All the time
9. Was the Morisky Medication Adherence section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

DRAFT

Allergies

1. Allergy Name(s) (specify all allergies):

2. Allergy Notes (specify for all allergies):

3. Intolerance Name (specify for all allergies):

4. Intolerance Notes (specify for all allergies):

5. Was the Allergies section completed in full?

- Yes – section completed in full
- No – not yet completed
- No – participant refused to answer one or more questions

<u>Vitals</u>	
1. Blood Pressure Sitting (systolic/diastolic)	
2. Heart Rate	
3. Weight (lbs.)	
4. Height (inches)	
5. BMI (calculated automatically)	
6. Temperature	
7. Pain (indicate zero to 10, with zero being no pain and 10 being the most intense pain)	
8. A1C Number	
9. Oxygen Saturation %	
10. Home Blood Glucose	
11. Edema (select one)	<input type="checkbox"/> Absent <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> +4
12. Respiratory rate	
13. Vitals Notes:	
14. Was the Vitals section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

Physical Self-Maintenance Scale (PSMS): Activities of Daily Living (ADLs)

1. Toileting Hygiene	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
2. Feeding or Eating	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
3. Dressing Upper Body	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
4. Dressing Lower Body	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
5. Grooming	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
6. Bathing	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
7. Toilet Transferring	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
8. Transferring	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
9. Ambulation/Locomotion	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
10. Was the PSMS/ADLs section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions	

<u>Instrumental Activities of Daily Living (IADLs)</u>		
1. Telephone	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
2. Traveling	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
3. Shopping	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
4. Preparing Meals	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
5. Housework	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
6. Medications	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
7. Money	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
8. Was the IADLs section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions	

Nutrition Screen (DETERMINE)

These questions identify older persons at risk for low nutrient intake and subsequent health problems. Communicate to participant: *“What you eat does affect your health. These questions help us determine any if you are at nutritional risk.”*

Summing the scores associated with each Yes answer indicates:

- Low nutritional risk = score 0-2
- Moderate nutritional risk = score 3-5
- High nutritional risk = score 6 or more

1. Have you made any changes in lifelong eating habits because of health problems?	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
2. Do you eat fewer than two meals a day?	<input type="checkbox"/> Yes (3) <input type="checkbox"/> No (0)
3. Do you eat fewer than five servings (1/2 cup each) of fruits and vegetables every day?	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
4. Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
5. Do you sometimes not have enough money to buy food?	<input type="checkbox"/> Yes (4) <input type="checkbox"/> No (0)
6. Do you have trouble eating due to problems with biting, chewing, or swallowing?	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
7. Do you eat alone most of the time?	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
8. Without wanting to, have you lost or gained ten pounds in the last six months?	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
9. Are you not always physically able to shop, cook, and/or feed yourself (or get someone to do it for you?)	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)

10. Do you have three or more drinks of beer, liquor, or wine almost every day?	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
11. Do you take three or more prescriptions or over-the-counter drugs per day?	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Total Score:	
12. Was the Nutrition Assessment section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

DRAFT

Falls Risk Assessment (STEADI)

These questions identify persons at risk for falling.

Sum the scores associated with each “Yes” answer. Scores of 4 points or more indicate the participant may be at risk for falling.

Question	Why it matters	Answer
1. I have fallen in the past year.	People who have fallen once are likely to fall again.	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
2. I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
3. Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
4. I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
5. I am worried about falling.	People who are worried about falling are more likely to fall.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
6. I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
7. I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
8. I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)

9. I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
10. I take medicine that sometimes make some feel lightheaded or more tired than usual.	Side effects from medicines can sometimes increase you a chance of falling.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
11. I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Total Score:		
12. Was the Falls Risk Assessment section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions	

Mini Cog

Begin the cognitive assessment with word recall.

Have the participant repeat the following three words right after you say them: **Telephone, umbrella, flowers.**

This is to make sure they heard and understood the words correctly.

Next, provide a blank piece of paper to the participant and ask them to do the following steps:

- First, draw the face of a clock and put all of the numbers on it. Make it large.
- Now, draw the hands, point at 20 minutes before 4 O'clock, Good.

Keep the clock drawing.

Ask the participant, “**Please tell me the three words I asked you to remember earlier.**” Note how many words the participant was able to recall.

Next, is the category fluency, please make sure you have a timing device available. Say, “When I tell you to start, please name as many kinds of animals as you can think of in one minute. Ok?” When the person is ready. Say, “begin” and start the timer. At the end of 60 seconds stop the timer and say, “Ok, that’s good. Thank you.” Keep track of how many animals they named here (which animal is not important).

1. Clock Drawing	5-7 points = passing score 4 points = borderline 0-3 points = failing score
2. Three Word Recall (1 point for each word correctly recalled)	3 points = passing score 2 points = borderline 1-0 points = failing score
3. Category Fluency	>15 animals named within the one minute = passing score 15 animals = borderline <15 animals = failing score
4. Total Cognitive Ability Score: Pass/Fail (Fail if: fail 2 or more components OR scores “borderline” on 2 of 3 components)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
5. Participant is unable to perform the cognitive screen	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Additional information about cognitive assessment:

7. Was the Mini Cog section completed in full?

- Yes – section completed in full
- No – not yet completed
- No – participant refused to answer one or more questions

DRAFT

Use this page for the Mini Cog:

DRAFT

Use this page for the Mini Cog:

DRAFT

Loneliness Scale

The scores of each individual question can be added together to give range of scores from 3 to 9. Researchers have grouped people who score 3-5 as “not lonely” and people with a score of 6-9 as “lonely.”

1. How often do you feel that you lack companionship?	<input type="checkbox"/> Hardly ever (1) <input type="checkbox"/> Often (3)	<input type="checkbox"/> Some of the time (2) <input type="checkbox"/> Not performed
2. How often do you feel left out?	<input type="checkbox"/> Hardly ever (1) <input type="checkbox"/> Often (3)	<input type="checkbox"/> Some of the time (2) <input type="checkbox"/> Not performed
3. How often do you feel isolated from others?	<input type="checkbox"/> Hardly ever (1) <input type="checkbox"/> Often (3)	<input type="checkbox"/> Some of the time (2) <input type="checkbox"/> Not performed
4. Was the Social Connectedness section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions	

Behavioral Health	
1. How many times in the past year have you had four or more alcoholic drinks in a day? (select one)	<input type="checkbox"/> Zero <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more times
If answer above is “Two” or “Three or more,” complete the S-MAST-G below.	
2. What is your current relationship with tobacco (select one)?	<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current tobacco user <input type="checkbox"/> Currently exposed to second hand smoke <input type="checkbox"/> No for medical reasons
3. Would you like assistance with tobacco cessation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not now <input type="checkbox"/> N/A
4. Notes:	
5. Was the Behavioral Health section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions

DRAFT

S-MAST-G

Two or more “Yes” answers below indicate the need for a brief intervention and possibly a referral for assessment and treatment.

1. When talking to others, do you ever understate how much you actually drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. When drinking, have you sometimes skipped a meal because you did not feel hungry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does having a few drinks help reduce shakiness or tremors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does alcohol sometimes make it hard for you to remember parts of a day or night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you usually take a drink to relax or calm your nerves?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you drink to take your mind off problems like feeling alone or being in physical or emotional pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you increased your drinking after experiencing a loss in your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has a doctor, nurse, or other health care provider ever said that they were concerned about your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you tried to reduce your drinking from your own concern or to try and manage the amount of your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. When you feel lonely does having a drink help you feel better?	<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Do you drink alcohol and at the same time use mood or mind altering drugs, including prescription, tranquilizers, prescription sleeping pills, prescription pain pills, or illicit drugs?

Yes No

12. Notes:

13. Was the S-MAST-G section completed in full?

- Yes – section completed in full
- No – not yet completed
- No – participant refused to answer one or more questions
- Not applicable

General Anxiety Disorder Scale (GAD-2)

- | | |
|--|---|
| 1. Over the past two weeks, how often have you been bothered by feeling nervous, anxious, or on edge (circle one)? | 0 – Not at all
1 – Several days
2 – more than half the days
3 – Nearly every day |
| 2. Over the past two weeks how often have you been bothered not being able to stop or control worrying (circle one)? | 0 – Not at all
1 – Several days
2 – more than half the days
3 – Nearly every day |

Total Score:

If the total score from two GAD-2 questions above is 3 or higher, complete GAD-7 below.

General Anxiety Disorder Scale (GAD-7)

Scoring: Sum points from all GAD-7 answers: 5-9 Mild Anxiety, 10-14 Moderate Anxiety, 15 + Severe Anxiety

1. Over the last two weeks, how often have you been bothered by feeling nervous, anxious, or on edge?	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
2. Over the last two weeks, how often have you been bothered by not being able to stop or control worrying	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
3. Over the last two weeks, how often have you been worrying too much about different things	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
4. Over the last two weeks, how often have you had trouble relaxing	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
5. Being so restless that it is hard to sit still	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day

6. Becoming easily annoyed or irritable	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
7. Feeling afraid as if something awful might happen	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
8. If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult
Total Score:	
9. Was the GAD-7 section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions <input type="checkbox"/> Not applicable

Patient Health Question-2 (PHQ-2): Depression Screener

1. Over the past two weeks, how often have you been had little interest or pleasure in doing things	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
---	---

2. Over the past two weeks, how often have you felt down, depressed, or hopeless	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
--	---

Total Score:

If the total PHQ-2 score is 3 or greater complete the PHQ-9

3. Was the PHQ-2 section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions
---	--

Patient Health Question-9 (PHQ-9)

For participants who scored 3 or greater total points on the PHQ-2 complete this section. .

Ask the participant: *“Over the past two weeks, how often have you been bothered by any of the following problems?”*

1. Over the past two weeks, how often have you had trouble falling asleep, staying asleep, or sleeping too much	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
---	---

<p>2. Over the past two weeks, how often have you felt tired or had little energy</p>	<p>0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day</p>
<p>3. Over the past two weeks, how often have you been bothered by poor appetite or overeating</p>	<p>0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day</p>
<p>4. Over the past two weeks, how often have you been bothered by feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down</p>	<p>0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day</p>
<p>5. Over the past two weeks, how often have you been bothered by trouble concentrating on things such as reading the newspaper or watching television</p>	<p>0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day</p>
<p>6. Over the past two weeks, how often have you been bothered by moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.</p>	<p>0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day</p>

7. Over the past two weeks, how often have you been bothered by thinking that you would be better off dead or that you want to hurt yourself in some way	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Total Score:	
<p>Take the total score from PHQ-2 and add to the sum of the additional questions.</p> <p>0-4 = minimal depression, 5-9 = mild, 10-14 = moderate, 15-19 = moderately severe, 20-27 = severe.</p>	
8. Was the PHQ-9 section completed in full?	<input type="checkbox"/> Yes – section completed in full <input type="checkbox"/> No – not yet completed <input type="checkbox"/> No – participant refused to answer one or more questions <input type="checkbox"/> Not applicable

Assessment Status

1. If the IWISH health and wellness assessment was not completed in full, please indicate the reason(s) why. (select all that apply)	<input type="checkbox"/> Participant declined to complete one or more sections <input type="checkbox"/> Participant did not respond to at least three attempts to contact <input type="checkbox"/> Participant already has completed an assessment with another program <input type="checkbox"/> Other reason
--	--

Supplemental Medication Review

Medication (enter name of medication):

<p>11. Medication Review Prescription Status (select all that apply)</p>	<p><input type="checkbox"/> New taken < 1 week <input type="checkbox"/> Ongoing <input type="checkbox"/> Review requested <input type="checkbox"/> Discontinued <input type="checkbox"/> Prescription not filled <input type="checkbox"/> Refill overdue <input type="checkbox"/> Other</p>
<p>12. Why are you taking this medication?</p>	
<p>13. Does the participant seem to understand why they are taking this medication?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>
<p>14. Are you able to read the prescription label?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>
<p>15. How do you take this medication? (select all that apply)</p>	<p><input type="checkbox"/> Self (i.e., the participant) <input type="checkbox"/> Caregiver <input type="checkbox"/> RN <input type="checkbox"/> Unknown <input type="checkbox"/> Other</p>

<p>16. Where do you store this medication? (select one)</p>	<input type="checkbox"/> Bag <input type="checkbox"/> Bathroom cabinet <input type="checkbox"/> Refrigerator <input type="checkbox"/> Bathroom counter <input type="checkbox"/> Box <input type="checkbox"/> Kitchen cabinet <input type="checkbox"/> Kitchen counter <input type="checkbox"/> Mixed containers <input type="checkbox"/> Multiple locations <input type="checkbox"/> Night stand <input type="checkbox"/> Other
<p>17. Would you like to consider an alternative medication, if available? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>18. Would you like to speak with your doctor or pharmacist about this medication? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>19. Does this participant share their medication with anyone? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>20. After reviewing all of this participant's medications, is an additional medication review or medication reconciliation recommended? (select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A