

Care Partner Assessment Packet

We understand that life is busy, and it is difficult to complete another packet of papers. However, this information helps us understand the current state of health, function and coping so that we can identify goals and plan our next steps together.

This packet was developed by a group of national geriatric experts. Medicare recommends that this assessment be completed every 6 months to assess the current situation and evaluate and prioritize our care goals and plans.

Patient Name: _____ **Patient Date of Birth:** _____

Completed by: _____ **Date Completed:** _____

Next Appointment: _____ **Return this form by:** _____

INSTRUCTIONS:

- This form should be completed by the care partner/family/friend about the patient. This allows us to “see the big picture” and better understand what you are observing and experiencing as a caregiver.
- Complete and return this form to the office by: _____
- Complete this packet within one month of the next appointment. We want to be sure that your answers are current, and we know that situations change.
- Do not “over think.” Choose the answer that best matches the current situation.

ABOUT THIS PACKET AND THE CARE PARTNER ASSESSMENT:

- This packet was developed by a group of national geriatric experts. Regularly repeated evaluations help us better understand your needs so that we can adjust our goals and plans for your care over time.
- You will be asked to repeat this paperwork in the future.
- Comparing your answers over time helps us identify changing needs, adjust our goals and plans, and identify ways to provide additional support.
- Repeated Cognitive Care Partner Assessments help us plan ahead so that you and your loved one are better prepared for future changes and needs before they happen.

Thank you for taking the time to complete this packet. Your input as caregiver is valuable!

See the last page of this packet for helpful resources.

Care Partner Assessment Packet

Patient/Participant Name: _____ Date of Birth _____

Safety Assessment Checklist:

Question	Yes	No
Is the patient still driving?		
Is the patient taking medication as prescribed?		
Are there any concerns about safety in the home?		
Has the patient gotten lost in familiar places?		
Are there any firearms in the home?		
Is the patient unsteady, off balance, or experienced falls?		
Does the patient live alone?		

Katz Index of Independence in Activities of Daily Living		
Activities Points (1 or 0)	Independence (1 Point)	Dependence (0 Points)
	NO supervision, direction or personal assistance.	WITH supervision, direction, personal assistance or total care.
BATHING Points: _____	(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) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	(1 POINT) Get 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 Points: _____	(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 Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	(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: _____ SCORING: 6 = High (<i>patient independent</i>) 0 = Low (<i>patient very dependent</i>)		

Source: *try this*: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.



Patient/Participant Name: _____ Date of Birth _____

LAWTON-BRODY INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instructions: Circle 1 for mostly independent or 0 for needs assistance.

LAWTON - BRODY INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)			
Scoring: For each category, circle the item description that most closely resembles the client’s highest functional level (either 0 or 1).			
A. Ability to Use Telephone		E. Laundry	
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
2. Dials a few well-known numbers	1	2. Launders small items-rinses stockings, etc.	1
3. Answers telephone but does not dial	1	3. All laundry must be done by others	0
4. Does not use telephone at all	0		
B. Shopping		F. Mode of Transportation	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation		G. Responsibility for Own Medications	
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
D. Housekeeping		H. Ability to Handle Finances	
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		
Score		Score	
Total score _____			
A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.			

Source: *try this*: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.



Patient/Participant Name: _____ Date of Birth _____

DEMENTIA SEVERITY RATING SCALE (DSRS)

Name of person completing form: _____

Relationship to patient/participant: Spouse Sibling Child Friend Other _____

How much time do you spend with patient on average each week?

- We live together Daily More than 5 days/week
- Less than one day/week 1 day/week 2 days/week 3-4 days/week

In each section below, circle the number that most closely applies to the participant *most of the time*.

MEMORY

- 0 Normal memory.
- 1 Occasionally forgets things that they were told recently.
Does not cause many problems.
- 2 Mild consistent forgetfulness. Remembers recent events but often forgets parts.
- 3 Moderate memory loss. Worse for recent events. May not remember something you just told them.
Causes problems with everyday activities.
- 4 Substantial memory loss. Quickly forgets recent or newly-learned things. Can only remember things that they have known for a long time.
- 5 Does not remember basic facts like the day of the week, when last meal was eaten or what the next meal will be.
- 6 Does not remember even the most basic things.

SPEECH AND LANGUAGE

- 0 Normal ability to talk and to understand others.
- 1 Sometimes cannot find a word, but able to carry on conversations.

- 2 Often forgets words. May use the wrong word in its place. Some trouble expressing thoughts and giving answers.
- 3 Usually answers questions using sentences but rarely starts a conversation.
- 4 Answers questions, but responses are often hard to understand or don't make sense. Usually able to follow simple instructions.
- 5 Speech often does not make sense. Can not answer questions or follow instructions.
- 6 Does not respond most of the time.

RECOGNITION OF FAMILY MEMBERS

- 0 Normal - recognizes people and generally knows who they are.
- 1 Usually recognizes grandchildren, cousins or relatives who are not seen frequently but may not recall how they are related.
- 2 Usually does not recognize family members who are not seen frequently. Is often confused about how family members such as grandchildren, nieces, or nephews are related to them.
- 3 Sometimes does not recognize close family members or others who they see frequently. May not recognize their children, brothers, or sisters who are not seen on a regular basis.
- 4 Frequently does not recognize spouse or caregiver.
- 5 No recognition or awareness of the presence of others.



Patient/Participant Name: _____ Date of Birth _____

ORIENTATION TO TIME

- 0 Normal awareness of time of day and day of week.
- 1 Some confusion about what time it is or what day of the week, but not severe enough to interfere with everyday activities.
- 2 Frequently confused about time of day.
- 3 Almost always confused about the time of day.
- 4 Seems completely unaware of time.

ORIENTATION TO PLACE

- 0 Normal awareness of where they are even in new places.
- 1 Sometimes disoriented in new places.
- 2 Frequently disoriented in new places.
- 3 Usually disoriented, even in familiar places. May forget that they are already at home.
- 4 Almost always confused about place.

ABILITY TO MAKE DECISIONS

- 0 Normal - as able to make decisions as before.
- 1 Only some difficulty making decisions that arise in day-to-day life.
- 2 Moderate difficulty. Gets confused when things get complicated, or plans change.
- 3 Rarely makes any important decisions. Gets confused easily.
- 4 Not able to understand what is happening most of the time.

SOCIAL AND COMMUNITY ACTIVITY

- 0 Normal - acts the same with people as before
- 1 Only mild problems that are not really important, but clearly acts differently from previous years.
- 2 Can still take part in community activities without help. May appear normal to people who don't know them.
- 3 Often has trouble dealing with people outside the home without help from caregiver. Usually, can participate in quiet home activities with friends. The problem is clear to anyone who sees them.
- 4 No longer takes part in any real way in activities at home involving other people. Can only deal with the primary caregiver.
- 5 Little or no response even to primary caregiver.

HOME ACTIVITIES AND RESPONSIBILITIES

- 0 Normal. No decline in ability to do things around the house.
- 1 Some problems with home activities. May have more trouble with money management (paying bills) and fixing things. Can still go to a store, cook or clean. Still watches TV or reads a newspaper with interest and understanding.
- 2 Makes mistakes with easy tasks like going to a store, cooking or cleaning. Losing interest in the newspaper, TV or radio. Often can't follow a long conversation on a single topic.
- 3 Not able to shop, cook or clean without a lot of help. Does not understand the newspaper or the TV. Cannot follow a conversation.
- 4 No longer does any home-based activities.



Patient/Participant Name: _____ Date of Birth _____

PERSONAL CARE - CLEANLINESS

- 0 Normal. Takes care of self as well as they used to.
- 1 Sometimes forgets to wash, shave, comb hair, or may dress in wrong type of clothes. Not as neat as they used to be.
- 2 Requires help with dressing, washing and personal grooming.
- 3 Totally dependent on help for personal care.

EATING

- 0 Normal, does not need help in eating food that is served to them.
- 1 May need help cutting food or have trouble with some foods, but basically able to eat by themselves.
- 2 Generally able to feed themselves but may require some help. May lose interest during the meal.
- 3 Needs to be fed. May have trouble swallowing.

CONTROL OF URINATION AND BOWELS

- 0 Normal - does not have problems controlling urination or bowels except for physical problems.
- 1 Rarely fails to control urination (generally less than one accident per month).
- 2 Occasional failure to control urination (about once a week or less).
- 3 Frequently fails to control urination (more than once a week).
- 4 Generally fails to control urination and frequently cannot control bowels.

ABILITY TO GET FROM PLACE TO PLACE

- 0 Normal, able to get around on their own. (May have physical problems that require a cane or walker).
- 1 Sometimes gets confused when driving or taking public transportation, especially in new places. Able to walk places alone.
- 2 Cannot drive or take public transportation alone, even in familiar places. Can walk alone outside for short distances. Might get lost if walking too far from home.
- 3 Cannot be left outside alone. Can get around the house without getting lost or confused.
- 4 Gets confused and needs help finding their way around the house.
- 5 Almost always in a bed or chair. May be able to walk a few steps with help but lacks sense of direction.
- 6 Always in bed. Unable to sit or stand.

INTERPRETATION

Add up the points for all sections.

Score

0-18 - Mild

19-36 - Moderate

37-54 - Severe

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Pennsylvania, USA

Continued.....



Patient/Participant Name: _____ Date of Birth _____

NEUROPSYCHIATRIC INVENTORY QUESTIONNAIRE

Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems.

Circle "Yes" only if the symptom(s) has been present in the last month. Otherwise, circle "No". For each item marked "Yes":

a) Rate the SEVERITY of the symptom (how it affects the patient):

- 1 = Mild (noticeable, but not a significant change)
- 2 = Moderate (significant, but not a dramatic change)
- 3 = Severe (very marked or prominent, a dramatic change)

b) Rate the DISTRESS you experience due to that symptom (how it affects you):

- 0 = Not distressing at all
- 1 = Minimal (slightly distressing, not a problem to cope with)
- 2 = Mild (not very distressing, generally easy to cope with)
- 3 = Moderate (fairly distressing, not always easy to cope with)
- 4 = Severe (very distressing, difficult to cope with)
- 5 = Extreme or Very Severe (extremely distressing, unable to cope with)

Please answer each question carefully. Ask for assistance if you have any questions.

Delusions Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Hallucinations Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Agitation/Aggression Is the patient resistive to help from others at times, or hard to handle?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Depression/Dysphoria Does the patient seem sad or say that he /she is depressed?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5



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Anxiety

Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Elation/Euphoria

Does the patient appear to feel too good or act excessively happy?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Apathy/Indifference

Does the patient seem less interested in his/her usual activities or in the activities and plans of others?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Disinhibition

Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people's feelings?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Irritability/Lability

Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Motor Disturbance

Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Nighttime Behaviors

Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Appetite/Eating

Has the patient lost or gained weight, or had a change in the type of food he/she likes?

Yes No SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Neuropsychiatric Inventory Questionnaire Developed by Daniel Kaufer, MD. Final Version 6/99. © J.L. Cummings, 1994; all rights reserved

Totals: Severity: _____ Distress: _____



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Patient/Participant Name: _____ Date of Birth _____

Medications: Bring a current list to the appointment

Name of medication	Dose	How many? How many times a day?

End of Life Checklist

Question	Yes	No
Have wishes for End of Life been discussed?		
Is Power of Attorney in place?		
Is Health Care Proxy in place?		
Is Palliative or Hospice care appropriate?		

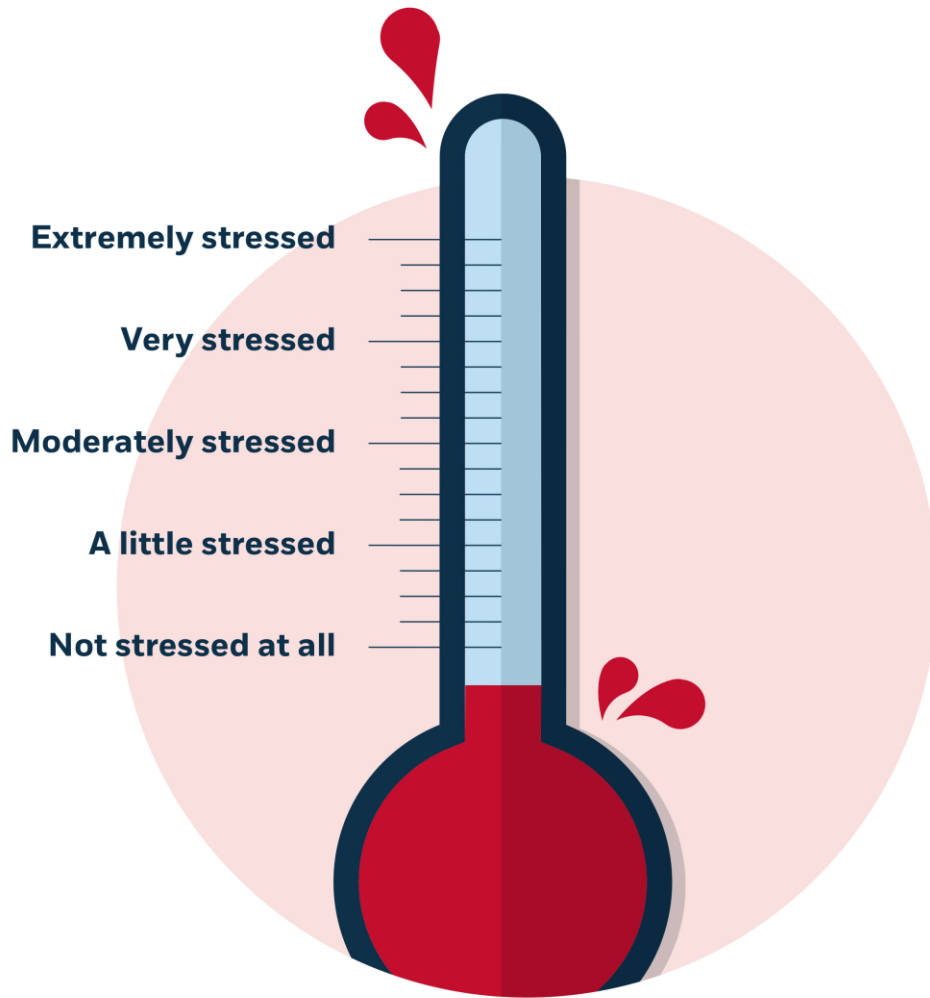
Caregiver Profile

Question	Yes	No
Do you understand Alzheimer’s Disease and other dementias?		
Do you know where to get additional information?		
Are you able and willing to provide care and/or assistance for your loved one?		
Do you know where to get caregiver support for yourself?		



Patient/Participant Name: _____ Date of Birth _____

CAREGIVER STRESS THERMOMETER



ID: _____ Date: _____

©S. Borson | *Reference: Elo A-L, Leppänen A, Jahkola A. Scand J Work Environ Health 2003;29(6):444-451.

**PLEASE RETURN THIS FORM TWO WEEKS BEFORE THE APPOINTMENT.
Return this form via The Patient Gateway, Mail, or Fax to:**

**Cooley Dickinson Geriatrics
22 Atwood Drive Suite 201
Northampton MA 01060
Fax 413-341-2261**



Patient/Participant Name: _____ Date of Birth _____

This page of resources is for you to keep.

HELPFUL RESOURCES

- The resources section of our website has many wonderful sources of information:
<https://www.cooleydickinson.org/programs-services/geriatrics/resources/>
- Highland Valley Elder Services 413-586-2000 (Hampshire County and Hilltown areas)
- Greater Springfield Elder Services 413-781-8800 (Hampden County area)
- WesternMass Elder Care: 413-38-9020 (Hampshire and Hampden County areas)
- LifePath 413-773-5555 (Franklin County area)
- 24/HR SUPPORT LINE: CSO 413-586-5555 OR ALZ.ORG 800-272-3900

Alzheimer's Association®

alz.org®

800.272.3900

Provides disease education, support groups, and personalized care consultation in person, online and through a free 24/7 Helpline.

Alzheimer's Disease Education and Referral (ADEAR)

nia.nih.gov/alzheimers

800.438.4380

Offers disease information online or by phone for individuals with Alzheimer's or other dementias and their families.

Administration on Community Living

alzheimers.gov

Supports individuals living with Alzheimer's or other dementias and their caregivers by increasing access to community resources.

ALZConnected®

alzconnected.org

Online community that connects individuals facing the disease and provides online support.

Community Resource Finder

alz.org/CRF

Find local programs, resources and support services.

Aging Life Care Association

aginglifecare.org

Locate a geriatric care manager.

Family Caregiver Alliance

caregiver.org

Offers support for family and friends providing long-term, in-home care.

Eldercare Locator

eldercare.gov

Connects older adults and their caregivers with local services and provides resource referrals and contact information for state and local agencies on aging.

