GERIATRIC SCREENING FOR: DOB:

Depression/Anxiety - Screen Total score > 3 for 1 & 2 = anxiety score > 3 for 3 & 4 = depression

PHQ4 Depression screen	0	1	2	3
1. Do you feel nervous or anxious?	No	sometimes	most of the time	all the time
2. Are you able to stop or control worry?	Yes	mostly	sometimes	no
3. Little interest in pleasure or doing things?	No	sometimes	most of the time	all the time
4. Do you feel sad, hopeless, or down?	No	sometimes	usually	all the time

Who do call when you need help? _____

Sensory	
Able to read magazines or the paper	1
Able to understand spoken voice in either ear	1
Mental Status	
Repeat "hat - pencil - apple" for recall later	1
Touch your knee, close your eyes, touch your nose	3
Name this place	1
What is the Season?	1
What is the month?	1
Where were you born	1
What is this called: Pen - Doorknob	2
How much is 2 quarters and a nickel?	1

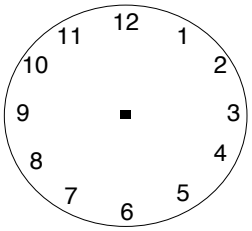
Points for naming:

0-2 =0 3-4 =1 5-7 =2 8-9 =3 10 =4 >10=5 Points

How many can you name: cities or towns	1 2 3 4 5
How many can you name: fruits or vegetables	1 2 3 4 5
Repeat the 3 objects "hat - pencil - apple"	3

Function	YES	NO
Able to use the toilet yourself?	1	0
Able to feed yourself?	1	0
Able to dress or groom yourself?	1	0
Do you pay your own bills?	1	0
Any trouble using the phone?	0	1
Any trouble operating the TV or radio?	0	1
Can you pick up something you drop?	2	0
Maneuver within confines of your home?	2	0
Rise from chair, walk to the door and come back		
Able to accomplish in 7-10 seconds	3	0
Able to accomplish in 10-20 seconds	1	0

Draw five past ten on the clock



Analysis of Geriatric Assessment:

	Sensory	Mental Status	Function
Most likely independent	≥1	≥19	>10
Requires some supervision	≥1	16 - 18	8 - 10
Requires moderate supervision	≤1	6 - 15	3 - 7
Requires living arrangement with 24 hrs of care	≤1	<6	<3

Notes: _____

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Signature Date