Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake ☐

B Weight loss during the last 3 months
0 = weight loss greater than 3kg (6.6lbs)
1 = does not know
2 = weight loss between 1 and 3kg (2.2 and 6.6 lbs)
3 = no weight loss ☐

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out ☐

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no ☐

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems ☐

F Body Mass Index (BMI) = weight in kg / (height in m)² ☐
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater ☐

Screening score (subtotal max. 14 points) ☐☐
12-14 points: ☐ Normal nutritional status
8-11 points: ☐ At risk of malnutrition
0-7 points: ☐ Malnourished
For a more in-depth assessment, continue with questions G-R

Assessment

G Lives independently (not in nursing home or hospital)
1 = yes 0 = no ☐

H Takes more than 3 prescription drugs per day
0 = yes 1 = no ☐

I Pressure sores or skin ulcers
0 = yes 1 = no ☐

J How many full meals does the patient eat daily?
0 = 1 meal
1 = 2 meals
2 = 3 meals ☐

K Selected consumption markers for protein intake
- At least one serving of dairy products (milk, cheese, yoghurt) per day yes ☐ no ☐
- Two or more servings of legumes or eggs per week yes ☐ no ☐
- Meat, fish or poultry every day yes ☐ no ☐

0.0 = if 0 or 1 yes
0.5 = if 2 yes
1.0 = if 3 yes ☐,☐

L Consumes two or more servings of fruit or vegetables per day?
0 = no 1 = yes ☐

M How much fluid (water, juice, coffee, tea, milk...) is consumed per day?
0.0 = less than 3 cups
0.5 = 3 to 5 cups
1.0 = more than 5 cups ☐,☐

N Mode of feeding
0 = unable to eat without assistance
1 = self-fed with some difficulty
2 = self-fed without any problem ☐

O Self view of nutritional status
0 = views self as being malnourished
1 = is uncertain of nutritional state
2 = views self as having no nutritional problem ☐

P In comparison with other people of the same age, how does the patient consider his / her health status?
0.0 = not as good
0.5 = does not know
1.0 = as good
2.0 = better ☐,☐

Q Mid-arm circumference (MAC) in cm
0.0 = MAC less than 21
0.5 = MAC 21 to 22
1.0 = MAC greater than 22 ☐,☐

R Calf circumference (CC) in cm
0 = CC less than 31
1 = CC 31 or greater ☐

Assessment (max. 16 points) ☐☐,☐
Screening score ☐☐,☐
Total Assessment (max. 30 points) ☐☐,☐

Malnutrition Indicator Score
24 to 30 points ☐ Normal nutritional status
17 to 23.5 points ☐ At risk of malnutrition
Less than 17 points ☐ Malnourished

Save Print Reset

References
1. Vellas B, Villars H, Abellan G, *et al.* Overview of the MNA® - Its History and Challenges. *J Nutr Health Aging.* 2006; 10:456-465.
2. Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). *J. Geront.* 2001; 56A: M366-377
3. Guigoz Y. The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us? *J Nutr Health Aging.* 2006; 10:466-487.

For more information: www.mna-elderly.com

TINETTI BALANCE & GAIT ASSESSMENT

BODYWORKShfr.com

For both assessments, enter the date of each exam and circle your rating for each item. Indicate totals at the bottom of each section.

BALANCE ASSESSMENT

To perform this assessment, seat the patient in a hard, armless chair.

Evaluated Function	Description of Behavior	Date: ___	Date: ___
Sitting Balance	Leans or slides in chair	0	0
	Steady, safe	1	1
Rises From Chair	Unable to rise without help	0	0
	Able to rise using arms to help	1	1
	Able to rise without using arms to help	2	2
Attempts To Rise	Unable to rise without help	0	0
	Able to rise, requires more than one attempt	1	1
	Able to rise, requires one attempt	2	2
Standing Balance (1st 5 Seconds)	Unsteady (staggers, moves feet, trunk sways)	0	0
	Steady, but uses walker or other support	1	1
	Steady without walker or other support	2	2
Standing Balance	Unsteady	0	0
	Steady, but with wide stance and uses support	1	1
	Narrow stance without support	2	2
Nudged	Begins to fall	0	0
	Staggers, grabs, catches self	1	1
	Steady	2	2
Eyes Closed	Unsteady	0	0
	Steady	1	1
Turning 360 Degrees	Discontinuous steps	0	0
	Continuous steps	1	1
	Unsteady (grabs, staggers)	0	0
	Steady	1	1
Sitting Down (Getting Seated)	Unsafe (misjudged distance, falls into chair)	0	0
	Uses arms or not a smooth motion	1	1
	Safe, smooth motion	2	2
	Balance Score		
	Potential Points: 16	16	16

GAIT ASSESSMENT

Stand with the patient. Walk across the room (+/- aids) at a usual pace, then rapidly

Evaluated Function	Description of Behavior	Date: ___	Date: ___
Indication of Gait	Any hesitancy or multiple attempts	0	0
	No hesitancy	1	1
Step Length & Height	Step to	0	0
	Step through right	1	1
	Step through left	1	1
Foot Clearance	Foot drop	0	0
	Left foot clears the floor	1	1
	Right foot clears the floor	1	1
Step Symmetry	Right and left step length are not equal	0	0
	Right and left step length appear equal	1	1
Step Continuity	Stopping of discontinuity between steps	0	0
	Steps appear continuous	1	1
Path	Marked deviation	0	0
	Mild/moderate deviation or uses a walking aid	1	1
	Straight without a walking aid	2	2
Trunk	Marked sway or uses a walking aid	0	0
	No sway, flexes knees/back/uses arms to balance	1	1
	No sway, no flexion of knees or back use of arms, or walking aid	2	2
Walking Time	Heels apart	0	0
	Heels almost touching while walking	1	1
	Gait Score		
	Potential Points: 12	12	12

Combined Score		
Potential Points For Balance & Gait	28	28

PT, Tinnetti Balance Assessment: 7/09

Risk of Falls: 18 Points or Less = High Risk, 19-23 Points = Moderate Risk, 24 or More Points = Low Risk

AFFIX STICKER

KATZ INDEX OF INDEPENDENCE IN ACTIVITIES OF DAILY LIVING*

Activities *POINTS (1 OR 0)*	***Independence*** *(1 POINT)* ***NO*** *supervision, direction, or personal assistance*	***Dependence*** *(0 POINT)* ***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) Needs help with bathing more than one part of the body, getting in or out of bathtub or shower. Requires total bathing.
DRESSING Points: _____	(1 point) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 points) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 point) Goes to toilet, gets on and off, arranges clothes, and 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 transferring aides 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: _____	*6 = High (client independent)*	*0 = Low (client very dependent)*

** Slightly adapted with permission from Gerontological Society of America. Katz, S., Down, T.D., Cash, H.R., et al. (1970). Progress in the development of the index of ADL.* The Gerontologist, 10, *20-30.*

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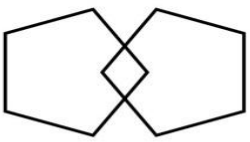
MINI MENTAL STATE EXAMINATION (MMSE)

Name:

DOB:

Hospital Number:

One point for each answer	**DATE:**		
ORIENTATION Year Season Month Date Time	...../ 5	...../ 5	...../ 5
Country Town District Hospital Ward/Floor	...../ 5	...../ 5	...../ 5
REGISTRATION Examiner names three objects (e.g. apple, table, penny) and asks the patient to repeat (1 point for each correct. THEN the patient learns the 3 names repeating until correct).	...../ 3	...../ 3	...../ 3
ATTENTION AND CALCULATION Subtract 7 from 100, then repeat from result. Continue five times: 100, 93, 86, 79, 65. (Alternative: spell "WORLD" backwards: DLROW).	...../ 5	...../ 5	...../ 5
RECALL Ask for the names of the three objects learned earlier.	...../ 3	...../ 3	...../ 3
LANGUAGE Name two objects (e.g. pen, watch).	...../ 2	...../ 2	...../ 2
Repeat "No ifs, ands, or buts".	...../ 1	...../ 1	...../ 1
Give a three-stage command. Score 1 for each stage. (e.g. "Place index finger of right hand on your nose and then on your left ear").	...../ 3	...../ 3	...../ 3
Ask the patient to read and obey a written command on a piece of paper. The written instruction is: "Close your eyes".	...../ 1	...../ 1	...../ 1
Ask the patient to write a sentence. Score 1 if it is sensible and has a subject and a verb.	...../ 1	...../ 1	...../ 1
COPYING: Ask the patient to copy a pair of intersecting pentagons 	...../ 1	...../ 1	...../ 1
TOTAL:	...../ 30	...../ 30	...../ 30

MMSE scoring

24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment