

Senior Quick Screen

This tool is meant for identifying possible indications that an older adult may benefit from further education, intervention, and referral. This screening tool is not designed to provide a diagnosis and results in isolation do not imply the need for treatment.

<p>Alcohol</p> <p>How often do you have a drink containing alcohol? <input type="radio"/> Once per day <input type="radio"/> Once per week <input type="radio"/> Once per month <input type="radio"/> I do not use alcohol at all.</p> <p>How many alcoholic beverages do you have on any one drinking occasion? List number if more than 9 <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> + _____</p>	<p>Suggestions for Considerations</p> <p><input type="checkbox"/> If any use of alcohol, provide information about alcohol use risks for older adults</p> <p><input type="checkbox"/> If has more than 1 drink per day, or more than 7 in one week, consider use of AUDIT or GMAST.</p> <p><input type="checkbox"/> if uses any alcohol and is currently taking medications, has health conditions, or family history of alcohol addiction alcohol screening, or consider the use of the AUDIT or GMAST.</p>
<p>Tobacco</p> <p>Do you use tobacco products? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>How many cigarettes do you smoke per day on the days that you smoke? 1 pack = 20 cigarettes # _____ cigarettes per day</p> <p><input type="radio"/> Fill in this circle if you have never smoked cigarettes</p> <p><input type="radio"/> Fill in this circle if you did not smoke in the past 30 days</p>	<p>Suggestions for Considerations</p> <p><input type="checkbox"/> If any use of tobacco, provide information about tobacco use risks for older adults and information for cessation options</p>
<p>Depression</p> <p>During the past two weeks, have you found little pleasure in the things you do? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>During the past two weeks, have you felt down, sad, or hopeless? <input checked="" type="radio"/> Yes <input type="radio"/> No</p>	<p>Suggestions for Considerations</p> <p><input type="checkbox"/> If yes to either, administer geriatric depression screening</p>
<p>Functioning</p> <p>Are you having trouble functioning in your environment? <input checked="" type="radio"/> Yes <input type="radio"/> No</p>	<p>Suggestions for Considerations</p> <p><input type="checkbox"/> If yes, may indicate need for further diagnostic work up and/or social services evaluation.</p>
<p>Medication</p> <p>Are you experiencing any problems with your prescription medications? <input checked="" type="radio"/> Yes <input type="radio"/> No</p>	<p>Suggestions for Considerations</p> <p><input type="checkbox"/> If yes, does client have medication list? If no, advise use of VIAL of LIFE</p> <p><input type="checkbox"/> If yes, does patient require additional education about prescribed/ OTC/ supplements? May indicate further need for physician inquiry, asking patient to bring all medications to next visit or list all medications for next visit.</p>
<p>Medical</p> <p>When was your last medical visit? _____</p> <p>How many physicians do you see? List number if more than 9. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> + _____</p>	<p>Suggestions for Considerations</p> <p><input type="checkbox"/> Multiple care providers may indicate need to prompt patient about importance of keeping all providers informed about their care, may also prompt need for collateral contacts.</p>
<p>Other Substances</p> <p>What other mood/mind altering substances you use, even if only occasionally? Please list all: _____ _____</p>	<p>Suggestions for Considerations</p> <p><input type="checkbox"/> If current use is indicated, may consider patient education and referral to a substance abuse treatment specialist for further evaluation.</p>

Senior Quick Screen

This tool is meant for identifying possible indications that an older adult may benefit from further education, intervention, and referral. This screening tool is not designed to provide a diagnosis and results in isolation do not imply the need for treatment.

<p>Alcohol</p> <p>How often do you have a drink containing alcohol?</p> <p><input type="radio"/> Once per day <input type="radio"/> Once per week <input type="radio"/> Once per month <input type="radio"/> I do not use alcohol at all.</p> <p>How many alcoholic beverages do you have on any one drinking occasion? List number if more than 9</p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 ⊕ _____</p>	
<p>Tobacco</p> <p>Do you use tobacco products?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>How many cigarettes do you smoke per day on the days that you smoke? 1 pack = 20 cigarettes</p> <p># _____ cigarettes per day</p> <p><input type="radio"/> Fill in this circle if you have never smoked cigarettes</p> <p><input type="radio"/> Fill in this circle if you did not smoke in the past 30 days</p>	
<p>Depression</p> <p>During the past two weeks have you found little pleasure in the things you do?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>During the past two weeks have you felt down, sad, or hopeless?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	
<p>Functioning</p> <p>Are you having trouble functioning in your environment?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	
<p>Medication</p> <p>Are you experiencing any problems with your prescription medications?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	
<p>Medical</p> <p>When was your last medical visit? _____</p> <p>How many physicians do you see? List number if more than 9.</p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 ⊕ _____</p>	
<p>Other Substances</p> <p>What other mood/mind altering substances you use, even if only occasionally? Please list all:</p> <p>_____</p> <p>_____</p>	