Senior Adult Supplement Screening Questionnaire (SAOP3)

1. Activities of Daily Living / Instrumental Activities of Daily Living (ADL/IADL):

(please check one for each line)

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<tr>
<td>a. Do you use a cane or a walker?</td>
<td>[ ] Yes</td>
<td>[ ] Occasionally</td>
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<td>b. Do you need help to get out of bed/chair?</td>
<td>[ ] Yes</td>
<td>[ ] Occasionally</td>
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<td>c. Have you tripped or fallen in the past year?</td>
<td>[ ] Yes</td>
<td>[ ] Occasionally</td>
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<tr>
<td>d. Do you have problems holding your urine or stools (more than small leaks controlled with a pad)?</td>
<td>[ ] Yes</td>
<td>[ ] Occasionally</td>
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<td>e. Can you dress yourself completely?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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<tr>
<td>f. Can you feed yourself?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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<tr>
<td>g. Are you able to drive?</td>
<td>[ ] Yes</td>
<td>[ ] Have never driven</td>
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<td>h. Are you able to prepare your own meals?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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<td>i. Are you able to go shopping?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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<td>j. Can you take care of your finances?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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<td>k. Can you use a telephone?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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<tr>
<td>l. Do you remember to take your medicines?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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<tr>
<td>m. Can you shower or bathe yourself completely?</td>
<td>[ ] Yes</td>
<td>[ ] Yes, but with help</td>
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2. Have you lost 5 or more pounds in the past 6 months without dieting? [ ] Yes [ ] No

3. Has your appetite decreased in the last 3 months? [ ] Yes [ ] No

4. Has there been a change in the types of foods you are able to eat? [ ] Yes [ ] No

5. Are you able to pay for your prescription medications? [ ] Yes [ ] No

6. Do you feel you are sleeping well? [ ] Yes [ ] No

7. If it was necessary, is there someone who could help take care of you, if needed? [ ] Yes [ ] No

8. Do you feel sad more days than not? [ ] Yes [ ] No

9. Have you lost interest in things you used to enjoy (hobbies, food, sex, being with friends/family)? [ ] Yes [ ] No

10. On a scale of 1 to 10, rate your present quality of life (10 is the best life, 1 is the worst). [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10

11. On a scale of 1 to 10, rate your present overall health (10 is the best health, 1 is the worst). [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10

Signature of Healthcare Professional __________________________ Time: ___________ Date: ___________
Instructions for the Mini-Cog

Step 1: Three Word Registration

Look directly at the patient and say, “Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. Please say them for me now.” If the person cannot repeat them after 3 times, move on to Step 2.

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<tbody>
<tr>
<td>Banana</td>
<td>Leader</td>
<td>Village</td>
<td>River</td>
<td>Captain</td>
<td>Daughter</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Season</td>
<td>Kitchen</td>
<td>Nation</td>
<td>Garden</td>
<td>Heaven</td>
</tr>
<tr>
<td>Chair</td>
<td>Table</td>
<td>Baby</td>
<td>Finger</td>
<td>Picture</td>
<td>Mountain</td>
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Step 2: Clock Drawing

Say “Next I want you to draw a clock for me. First put the numbers where they go.” When that is completed “Now set the hands to 10 past 11.”

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say “What were the three words I asked you to remember?”

Patient's answers
**MINI COG SCORING**

Number of correct items recalled: ___ (if 3 correct **Normal**, if 1-2 correct see clock results, if 0 correct: **Abnormal**)

If 1-2, is clock drawing abnormal?  [ ] Yes (cognitive impairment)  [ ] No (Normal)

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**ADL/IADL mobility items (1a-1d if at least two Yes responses) then consult**

[If YES/Occasionally to 1d, may administer the modified 3 Incontinence Questionnaire (3IQ)]

- [ ] Outpatient Physical Therapy
- [ ] Current treatment
- [ ] Pt declined

**ADL/IADL items (1e-1m):**

if more than one is **not YES** responses, then consult Outpatient Occupational Therapy

- [ ] PT
- [ ] OT
- [ ] Current treatment
- [ ] Pt declined

**Nutrition items (2-4):**

if at least two **Yes** responses, then consult

- [ ] Outpatient Nutrition
- [ ] Current treatment
- [ ] Pt declined

**Psychosocial items (7-9):**

if response is **No** to 1 and/or **Yes** to 2 or 3, then offer

- [ ] Behavioral Medicine
- [ ] Social Work
- [ ] Pt declined

**Quality of Life (QOL) and self-rated health items (10-11):**

if score less than 8, then consult

- [ ] Social Work
- [ ] Behavioral Medicine
- [ ] Pt declined

**Mini-Cog: + for cognitive impairment consult**

- [ ] Outpatient Occupational Therapy
- [ ] Speech Lang Path
- [ ] Neurology
- [ ] Pt declined

**Number of medications greater than 5, then consult**

- [ ] Pharmacy
- [ ] Pt declined

If **No** to # 5, refer to

- [ ] Social Work
- [ ] Patient Financial Services
- [ ] Pt declined

If **No** to # 6 administer Pittsburg Sleep Quality Index (PSQI) for further referral

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**Signature of Healthcare Professional: ___________________________ Time: __________ Date: __________**

**Printed name of Healthcare Professional: ___________________________ Pager number: ________________**