

8. Getting dressed or undressed

1 2 3 4 5 6 7 8 9 10
very confident not confident at all

9. Personal grooming (i.e. washing your face)

1 2 3 4 5 6 7 8 9 10
very confident not confident at all

10. Getting on and off the toilet

1 2 3 4 5 6 7 8 9 10
very confident not confident at all

Patient Specific Functional Scale

List 5 tasks that you have difficulty with as a result of your hand involvement

Then rate that task on a scale of 0 to 10

10 = unable; 0 = normal/no problem

Task	Rating
1.	
2.	
3.	
4.	
5.	

Quick Dash

Please answer every question based on your condition in the last week, by selecting the appropriate option. If you did not have the opportunity to perform an activity in the past week, please make your best estimate. It does not matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Open a tight or new jar.

Not Tested No Difficulty Mild Difficulty Moderate Difficulty Severe Difficulty Unable

2. Do heavy household chores (e.g. wash walls/floors).

Not Tested No Difficulty Mild Difficulty Moderate Difficulty Severe Difficulty Unable

3. Carry shopping bag or briefcase.

Not Tested No Difficulty Mild Difficulty Moderate Difficulty Severe Difficulty Unable

4. Wash your back.

Not Tested No Difficulty Mild Difficulty Moderate Difficulty Severe Difficulty Unable

5. Use a knife to cut food.

Not Tested No Difficulty Mild Difficulty Moderate Difficulty Severe Difficulty Unable

6. Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g. golf, hammering, tennis etc.)

Not Tested No Difficluty Mild Difficulty Moderate Difficulty Severe Difficulty Unable

7. During the past week to what extent has your arm, shoulder, or hand problems interfered with your normal social activites with family, friends, neighbors or groups?

Not Tested Not at all Slightly Moderately Quite a bit Extremely

8. During the past week were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problem?

Not Tested Not At All Slightly Limited Moderately Limited Very Limited Unable

9. Arm, shoulder or hand pain.

Not Tested None Mild Moderate Severe Extreme

10. Tingling (pins & needles) in your arm, shoulder, or hand.

Not Tested None Mild Moderate Severe Extreme

11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?

Not Tested No Difficulty Mild Difficulty Moderate Difficulty Severe Difficulty So Much Difficulty That I Can't Sleep

Geriatric Depression Scale

Instructions:

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? Yes **No**
2. Have you dropped many of your activities and interests? **Yes** No
3. Do you feel that your life is empty? **Yes** No
4. Do you often get bored? **Yes** No
5. Are you in good spirits most of the time? Yes **No**
6. Are you afraid that something bad is going to happen to you? **Yes** No
7. Do you feel happy most of the time? Yes **No**
8. Do you often feel helpless? **Yes** No
9. Do you prefer to stay at home, rather than going out and doing new things? **Yes** No
10. Do you feel you have more problems with memory than most? **Yes** No
11. Do you think it is wonderful to be alive now? Yes **No**
12. Do you feel pretty worthless the way you are now? **Yes** No
13. Do you feel full of energy? Yes **No**
14. Do you feel that your situation is hopeless? **Yes** No
15. Do you think that most people are better off than you are? **Yes** No

Score Meaning:

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression

A score ≥ 10 points is almost always indicative of depression

A score > 5 points should warrant a follow-up comprehensive assessment

Copyright: Bring, TL., Yesavage, JA., Lum, O., Heersema, P., Adey, MB., Rose, TL.: Screening tests for geriatric depression. Clinical Gerontologist 1: 37-44, 1982.

Instructions:

Questions 1-5 asked of patient. Question 6 asked by doctor within the last 12 months.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?

- Yes
- No
- Did not answer

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?

- Yes
- No
- Did not answer

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

- Yes
- No
- Did not answer

4. Has anyone tried to force you to sign papers or to use your money against your will?

- Yes
- No
- Did not answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

- Yes
- No
- Did not answer

6. Doctor: Elder abuse may be associated with fundings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

- Yes
- No
- Not Sure

Score Meaning:

Score Meaning: While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern.

Complete Medication List

Prescription medications/dosage/frequency/route of administration

	Drug name	Dosage	Frequency	Route of administration

Over the counter medications/dosage/frequency/route of administration

	Drug name	Dosage	Frequency	Route of administration

Herbals/dosage/frequency/route of administration

	Drug name	Dosage	Frequency	Route of administration

Vitamin/mineral/nutritional supplements/dosage/frequency/route of administration

	Drug name	Dosage	Frequency	Route of administration