IPOS-Dem

Practice Site Name: ..... Patient Identification #: .....
Assessment Date: ..... Setting: ❑ Office ❑ Nursing home
Assessment Type (check): ❑ Initial ❑ Status Change ❑ Routine
Insurance Type (check all that apply): ❑ Commercial ❑ Medicaid ❑ Medicare ❑ Uninsured

Q1. What have been the person's main problems over the past week?

1.....

2.....

3.....

Q2. Please select one box that best describes how the person has been affected by each of the following symptoms over the past week.

	Not at all	*Slightly*	*Moderately*	*Severely*	*Over-whelmingly*	*Cannot assess*	*Intervention offered or provided?*
Pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Shortness of breath	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Weakness or lack of energy	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Nausea (feeling like being sick/vomiting)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Vomiting (being sick)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Poor appetite	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Constipation	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Dental problems or problems with dentures	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Sore or dry mouth	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Drowsiness (sleepiness)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Poor mobility (trouble walking, cannot leave bed, falling)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes

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	Not at all	*Slightly*	*Moderately*	*Severely*	*Over-whelmingly*	*Cannot assess*	*Intervention offered or provided?*
Swallowing problems (e.g. chokes, inhales food or drink, holds food in mouth)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Skin breakdown (redness, skin tearing, pressure damage)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Difficulty communicating	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Sleeping problems	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Diarrhoea	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Hallucinations (seeing or hearing things not present) and/or delusions (fixed false beliefs)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Agitation (restless, irritable, aggressive)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
Wandering (as a result of distress or putting person at risk)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes

Has the person had any other symptoms? Please select one box to show how you feel each of these symptoms have affected the person over the past week (optional).

1.....0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
2.....0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes
3.....0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	❑ 0 No ❑ 1 Yes

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Over the past week:

	Not at all	Occasionally	Sometimes	Most of the time	Always	Cannot assess	Intervention offered or provided?
Q3. Has s/he been feeling anxious or worried?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes
Q4. Have any of his/her family been anxious or worried about the person?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes
Q5. Do you think s/he felt depressed?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes
Q5b. Lost interest in things s/he would normally enjoy?	☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes

Over the past week:

	Always	Most of the time	Sometimes	Occasionally	Not at all	Cannot assess	Intervention offered or provided?
Q6. Do you think s/he felt at peace?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes
Q7. Has s/he been able to interact positively with others (e.g. staff, family, residents)?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes
Q7b. Can s/he enjoy activities appropriate for his/her level of interests and abilities?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes
Q8. Has his/her family had as much information as wanted?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes

Over the past week:

	Problems addressed/ No problems	Problems mostly addressed	Problems partly addressed	Problems hardly addressed	Problems not addressed	Cannot assess	Intervention offered or provided?
Q9. Have all practical problems been addressed? [e.g. hearing aids, foot care, glasses, diet]	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes

	Health Care Proxy	Living Will	Organ Donation	Documentation of Oral Advance Directive	None	Cannot assess	Intervention offered or provided?
Q10. Check all advance directives known to have been completed:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ 0 No ☐ 1 Yes

What was the person's last weight and the date s/he was last weighed? Weight .....lbs

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