HOUSE CALLS POCKET GUIDE

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Yesavage Geriatric Depression Scale (GDS) – Short Form

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 _____/15 "depressed" answers (NO on 1, 5, 7, 11, 13; YES on others)	NORMS	
	Normal	3 ± 2
	Mildly depressed	7 ± 3
	Very depressed	12 ± 2

Adapted from Sheikh & Yesavage: *Clin Gerontol* 5:165. 1986

PATIENTS APPROPRIATE FOR HOUSE CALLS:

Require special transportation
Behaviorally difficult
Terminally ill / Home hospice
Caregiver burnout issues
Elder abuse / neglect in question
Chronic office "no shows"
Follow-up of recent hospitalization
Frequent falling
Recurrent medication nonadherence
Newborn visits

CONTENTS OF THE HOUSE CALL BAG

Sphygmomanometer
Stethoscope
Otoscope
Ophthalmoscope
Tongue depressor
Hemocult cards and developer
Gloves
Toe nail clippers
Surgilube
Prescription pads
Sterile specimen cup
Blood draw supplies and tubes
4x4 gauze and tape
alcohol wipes

OPTIONAL/SEASONAL

Pulse Oximeter
Portable EKG machine
Foley catheter kit
Influenza vaccine
Pneumovax
Tetanus
B12 injections
Childhood vaccines
Culturettes
Scale

ELEMENTS OF THE GERIATRIC HOUSE CALL

Medical H & P as appropriate
Cognitive Assessment – MMSE, Judgment questions, GDS
Functional Assessment

- Observe ambulation in home
  - Ask patient to give you a tour of home
- Assess bathroom for grab bars, slip/fall hazards
- Talk with other members of the household about functional concerns

Medication Assessment

- Appropriate temperature
- Cleanliness / Pets
- Throw rugs
- Lighting
- Barriers to walkers, canes, wheelchairs
- Security
- Emergency contact information

Nutritional Assessment

- Food availability (refrigerator and cabinet survey)

STUDY ID #: ____________ DO NOT WRITE ABOVE THIS LINE HOSPITAL #: __________

Brief Pain Inventory (Short Form)

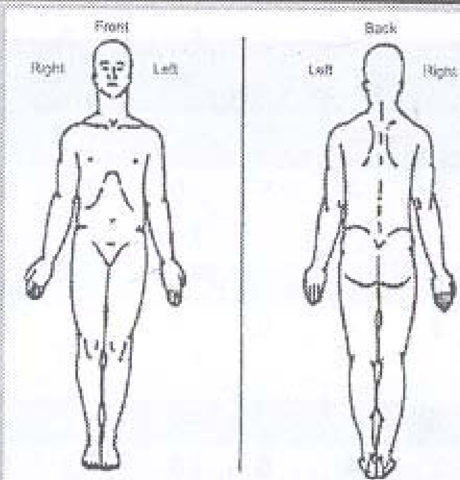
Date: ____/____/______ Time: __________

Name: ____________________ ____________________ ____________________
Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

   1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

0 No Pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 No Pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the **average**.

0 No Pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 No Pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

STUDY ID #: ____________ DO NOT WRITE ABOVE THIS LINE HOSPITAL #: ____________

Date: _____/_____/_____ Time: ____________

Name: ______________________ ______________________ ______________________

Last First Middle Initial

7. What treatments or medications are you receiving for your pain?

____

____

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% No Relief	10%	20%	30%	40%	50%	60%	70%	80%	90%	100% Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

B. Mood

0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

C. Walking Ability

0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

E. Relations with other people

0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

F. Sleep

0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

G. Enjoyment of life

0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

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Patient Name:______________________________
Examiner:________________________________
Date:____________________ **Time:**__________
Location:________________________________
Respondent if other than patient (name and relation):
____

1. **General Health:**
   "How would you describe your health?"
   Excellent / Good / Fair / Poor

2. **Activities of Daily Living**
   "Are you independent (I), require assistance (A), or dependent (D) with each of the following tasks?"

ADL	Ambulating	I	A	D
	Dressing	I	A	D
	Bathing	I	A	D
	Eating	I	A	D
	Toileting	I	A	D
IADL	Using Telephone	I	A	D
	Traveling	I	A	D
	Shopping	I	A	D
	Preparing Meals	I	A	D
	Housework	I	A	D
	Taking Medications	I	A	D
	Managing Finances	I	A	D

3. **Geriatric Review of Systems**
   Vision: "Do you have difficulty driving, watching TV, reading, or walking because of poor eyesight?"
   YES NO

   Hearing: Can the patient hear normal conversation voice?
   YES NO

   Memory: 3 item recall after 5 minutes (pony, quarter, orange)
   RECALLED ________ NO

3. **Geriatric Review of Systems (continued)**

Depression: "Do you often feel sad or depressed?"
YES NO

Nutrition: "Have you unintentionally lost weight in the last 6 months" YES NO

Incontinence:

"Do you have trouble with control of your bladder?"
YES NO

"Do you have trouble with control of your bowels?"
YES NO

Falls: How many falls have you had in the past year? _______

Alcohol: "Do you dink alcohol?" YES NO
If yes, "How many drinks per week?" __________

4. **Social Supports:**

"Do you live with anyone?" YES NO
Spouse / Child / Other Relative / Friend
"Who would help you in an emergency?" __________

5. **Polypharmacy:**

"How many medicine do you take including prescribed, over-the-counter and vitamins?" ____________________

"What is your system for taking your medicines?"
Pill Box / Family help / List or chart / None

6. **Elder Abuse:** "Has anyone intentionally tried to harm you?"
YES NO

7. **Immunizations:**

"Did you receive the flu shot?" (for the current or most recent season) YES NO

"Have you received a Pneumovax shot?" YES NO

Compiled from Lachs *et al Annuls of Internal Medicine* 1990; AA Moore *Am J Med* 100, 1998

Heppard /October 2001