Who Can Complete the Form: Social Services, Reflections/Passages Program Coordinators, Licensed Nurses, MDs, NPs, OTs, PTs, Residence Supervisors and Other Qualified Healthcare Professional who have been trained (and retrained annually) by viewing the VA-produced DVD (available upon request to tumosan@slu.edu).

Purpose of the Form: To screen individuals to look for the presence of cognitive deficits, and to identify changes in cognition over time.

Instructions for Use:
1. Complete resident demographics at the top of the page.
2. We recommend that you put the date and the name of the evaluator on the bottom of the page as well (see #19).
3. Administration should be conducted privately and in the examinee’s primary language. Be prepared with the items you need to complete the exam. You will need a watch with a second hand on it.
4. Record the number of years the patient attended school. If the patient obtained an Associates, Bachelor’s, Master’s or Doctorate degree, note the degree achieved instead of actual years of school attended.
5. Determine if the patient is alert. Do not answer “yes” or “no”, but indicate level of alertness. Alert indicates that the individual is fully awake and able to focus. Other descriptors include: drowsy, confused, distractible, inattentive, preoccupied.
6. Begin by asking the patient the following:
   “Do you have any trouble with your memory?” “May I ask you some questions about your memory?”
   Then proceed with the exam questions.
7. Read the questions aloud clearly and slowly to the examinee. It is not usually necessary to speak loudly but it is necessary to speak slowly.
8. Begin by asking the patient something similar to the following:
   “Do you have any trouble with your memory?” “May I ask you some questions about your memory?”
   “I’d like to see how good your memory is by asking you some questions.” You may need to reassure patients by telling them that this is not a test that they can fail but merely a tool much like a thermometer that takes temperature is a tool. What this does is checks for the amount of memory they have.
   Then begin to administer the exam questions.
9. Score the questions as indicated on the examination.
10. On question #4, read the statement as listed on the exam. Ask the patient to repeat each of the five objects (Apple, Pen, Tie, House, Car) that you recite to make sure that the patient heard and understood what you said. Repeat them as many times as it takes for the patient to repeat them back to you correctly.
11. On question #5, make sure the patient is focused on you prior to reciting the information. Obtain an answer for the first part of the question ("How much did you spend") before moving on to part two ("How much do you have left?"). Do not prompt or give hints, but do give ample time to the patient to answer the questions. If the patient asks you to repeat the question you may do so once.

12. Redirect the patient’s attention if necessary back to you to answer question #6. Give them one minute to complete the question. Be sure to time them.

13. Continue with the exam questions in the order that they are listed.

14. On question #8, state each number by its individual name. 87 is pronounced eight, seven; 649 is pronounced six, four, nine; 8537 is pronounced eight, five, three, seven.

15. On question #9, either draw a large circle on the back of the examination form or provide the patient with a separate piece of paper with a larger circle printed on it and attach it to the original examination form. When scoring, give full credit for either all 12 numbers or all 12 ticks. If the patient puts only 4 ticks on the circle, prompt them once to put numbers next to those ticks (12, 3, 6, and 9) for full credit. When scoring the correct time, make sure the hour hand is shorter than the minute hand and that the minute hand points at the 10 and the hour hand points at the 11.

16. You may also provide a separate sheet with larger examples of the forms listed on question #10 for those with vision impairment. This sheet should be created by enlarging the figures on the examination form and can also be attached to the original form.

17. Read question #11 as written, and provide ample time to answer each question. Do not repeat the story but do make sure they are paying attention the first time you read it to them. Do not prompt or give hints. The answer of Chicago as the state she lives in gets no credit but you may prompt them once by repeating the question.

18. Score the examination as listed at the bottom of the page, circling the level based on the score.

19. Sign and date the form.

20. Upon Completion of the Form:
   ✔ Record the score in the patient’s record and comment on any indicated changes
   ✔ Depending upon office protocols, either put the sheet in the patient’s record, place it in a separate identified location, or destroy the worksheet once the score is recorded in the patient record (Specify based on Office Center Policy)

21. Form Status: (Varies by office)
   Mandatory for (e.g., patients with diagnoses or indicators of cognitive loss)

   Mandatory for ________________________________

09/03/09