Live Well at Home

Rapid Screen©

Name: _____ **Screen Date: _____**

1.	**Do you need help to do the following?** a) Walking b) Getting out of bed/chair c) Going to the bathroom d) Bathing e) Dressing f) Eating **If 2 or more circled → SCORE = 2**	☐
2.	**During the last 6 months, have you had a fall that caused injuries? Yes No** NOTE: "Injuries" means fracture or joint dislocation, head injuries resulting in loss of consciousness and hospitalization, joint injuries that led to decreased activity, internal injuries that led to hospitalization <u>OR 3 or more of any falls.</u> **If YES circled SCORE = 2**	☐
3.	**Do you have a family member/friend give you help when you need it? Yes No** **If NO circled → SCORE = 2**	☐
4.	**Does your caregiver feel overwhelmed or stressed because of the care they provide you? Yes No** **If YES circled → SCORE = 2**	☐
5.	**Have you thought about moving to other housing? Yes No** **If YES, ask: where have you considered moving to?** **If answered NURSING HOME or ASSISTED LIVING (i.e., Housing With Services) → SCORE = 2**	☐
6.	**Do you live alone? Yes No** **If YES circled → SCORE = 1**	☐
7.	**Do you or your family have concerns about your memory, thinking, or ability to make decisions?** **If YES, are you: Very concerned Somewhat concerned Not concerned?** **If VERY CONCERNED circled → SCORE = 2** **If SOMEWHAT CONCERNED circled → SCORE = 1**	☐
	TOTAL SCORE (Sum of Scores For Items 1 Through 7) =	☐
<u>Score and Risk Category</u> **0 = No Risk 1 = Low Risk 2 = Moderate Risk 3 and up = High Risk**		

Revised 01.07.10