Concerns Mr/Mrs/Ms …… Personnel No: ……..

I. FUNCTIONAL INDEPENDENCE EVALUATION

ITEM	DESCRIPTION	SCORE
FEEDING	– Independent, can serve self from table/tray, takes a reasonable time to finish eating – Needs help, e.g. for cutting up food – Incapable of feeding self	10 ☐ 5 ☐ 0 ☐
BATHING	– Can take bath unaided – Incapable of bathing self	5 ☐ 0 ☐
PERSONAL TOILET	– Can wash face, comb hair, brush teeth, shave (plug in shaver) – Can do none of the above	5 ☐ 0 ☐
DRESSING/ UNDRESSING	– Independent. – Can tie shoelaces, use fasteners, put on braces – Needs help, but can do at least half of the task within a reasonable time – Can do none of the above	10 ☐ 5 ☐ 0 ☐
CONTINENCE OF BOWELS	– No accidents. Can use a suppository/enema when necessary – Occasional accidents. Needs help with suppositories/enemas -Incapable of using suppositories/enemas	10 ☐ 5 ☐ 0 ☐
BLADDER CONTROL	– No accidents. Can manage urine collection devices when necessary – Occasional accidents and needs help with collection devices – Incapable of using the equipment	10 ☐ 5 ☐ 0 ☐
GETTING ON AND OFF TOILET	– Can get on and off alone, or use a commode. Able to handle clothes, wipe self, flush toilet, empty commode – Needs help balancing, handling clothes or toilet paper – Can do none of the above	10 ☐ 5 ☐ 0 ☐
TRANSFERS FROM BED TO CHAIR/ WHEELCHAIR AND BACK	– Independent, can put brake on wheelchair and lower foot-rest – Minimal help or supervision needed – Can sit but needs major help for transfers – Completely dependent	15 ☐ 10 ☐ 5 ☐ 0 ☐
WALKING	– Can walk 50 metres without assistance. Can walk with crutches, but does not use wheeled devices – Can walk 50 metres with help – Can propel wheelchair independently for 50 metres, only if unable to walk – Incapable of walking	15 ☐ 10 ☐ 5 ☐ 0 ☐
ASCENDING/ DESCENDING STAIRS	– Independent. Can use crutches – Needs help or supervision – Incapable of using stairs	10 ☐ 5 ☐ 0 ☐
SUM TOTAL OF THE ABOVE		../100

The doctor must **tick a box** for each of the above items.

P.T.O. and complete

II. EVALUATION OF SPATIAL AND TEMPORAL AWARENESS

STATE OF PATIENT	EVALUATION OF OCCURRENCE OF PROBLEMS		SCORE
1. DIFFICULTIES IN EXPRESSION Making self understood through speech and/or signs	– always – occasionally, rarely – never		0 ☐ 5 ☐ 10 ☐
2. VERBAL DISRUPTION Shouting out for no reason and/or disturbing others by shouting and/or crying	– always – occasionally, rarely – never		0 ☐ 5 ☐ 10 ☐
3. LOSS OF SOCIAL INHIBITIONS Inappropriate behaviour at the table/meal times, taking clothes off at inappropriate times, urinating in inappropriate places, spitting…	– always – occasionally, rarely – never		0 ☐ 5 ☐ 10 ☐
4. TEMPORAL ORIENTATION	– completely disoriented – occasionally – no problem		0 ☐ 5 ☐ 10 ☐
5. AGITATED BEHAVIOUR Difficulty with interpersonal relationships, emotional disturbance and/or self-harming and/or psychomotor agitation (deambulation, fugue, etc.)	– always – occasionally, rarely – never		0 ☐ 5 ☐ 10 ☐
6. NOCTURNAL BEHAVIOUR Wandering around, disturbing others, confusing day and night	– always – occasionally, rarely – never		0 ☐ 5 ☐ 10 ☐
7. SPATIAL ORIENTATION	– completely disoriented – occasionally – no problem		0 ☐ 5 ☐ 10 ☐
8. DESTRUCTIVE BEHAVIOUR Violence towards physical surroundings/objects: clothes, furniture, reading material etc., and/or aggressive to others	– always – occasionally, rarely – never		0 ☐ 5 ☐ 10 ☐
9. MEMORY LOSS	(a) short-term	YES NO	0 ☐ 5 ☐
	b) long-term	YES NO	0 ☐ 5 ☐
10. RECOGNITION OF FAMILIAR PEOPLE Loss of ability to recognise…	close family (children, spouse)	YES NO	0 ☐ 5 ☐
	friends, acquaintances, etc.	YES NO	0 ☐ 5 ☐

GRANDTOTAL OF ALL ITEMS …./100

The doctor must **tick a box** for each of the above items.

…… Date

..... Doctor's signature and stamp