## Functional Disability Screening

### Target Areas Further Evaluation

<table>
<thead>
<tr>
<th>Area</th>
<th>Jaeger Care Score: Right eye</th>
<th>Left eye</th>
<th>Less than 20/40?</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISION</td>
<td>Right eye __ Left eye ___</td>
<td></td>
<td>Yes _____ No ______</td>
</tr>
<tr>
<td>HEARING</td>
<td>Right ear ___ Left ear ___</td>
<td></td>
<td>Impaired? Yes _____ No ______</td>
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### Arm Function

- Proximal: Touch back of head with both hands ___
- Distal: Pick-up pencil with each hand & put it back ___

### Leg Function

- Rise from chair ___
- Walk ten feet ___
- Turn and sit down ___

### Mental Status

- "I am going to name three objects. I will ask you to repeat them now and in a few minutes."
  - Apple _____ Table _____ Penny _____
- If unable to recall at 3 minutes, then (MMSE)

### Depression

- Do you often feel sad or depressed? ____ If yes:
  - Geriatric Depression Scale ___
  - GDS ≥ 5? Yes _____ No ______

### Home Environment

- Have you had any falls at home? ____ # of stairs? ___
- Throw rugs? ____ Bath rails? ____ Gas Stove? ___

### Activities of Daily Living

- Without assistance are you able to get out of bed? ___
- Dress? ____ Prepare meals? ____ Shop? ____

### Incontinence

- Do you ever lose your urine and get wet? ____ If yes:
  - Frequency ____ Amount ____ Time ____ Situation ___

### Nutrition

- Have you lost 10 lbs. or more in the past year? ___
- Amount ____ Current weight ____ Height ___

### Social Support

- Is there someone who would give you help if you were sick or disabled? ____
- Who? _____
- Who would be able to make health decisions for you if you were unable to make them yourself? _____

### DPOA Designated?

- Advanced Directives discussed? Yes _____ No ______

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**Remarks:**

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