



# **JBN Memory Health Clinic Consultation**

*Internal Medicine - Respiriology – Geriatrics – Allergy – Immunology – Asthma – Bariatric Medicine  
Health Clinics - Clinical Research - Cardiac Diagnostics*

*Dr. W.A. Nisker / Dr. J.C. Berlingieri / Dr. M. Cyr / Dr. M. Messieh*

PATIENT NAME: \_\_\_\_\_

DATE OF VISIT: \_\_\_\_\_

DRIVING STATUS/DETAILS: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ALLERGIES/ADVERSE REACTIONS: \_\_\_\_\_

MEDICAL CONDITIONS (PREVIOUS DIAGNOSIS): \_\_\_\_\_

HISTORY OF STROKE OR HEAD INJURY: \_\_\_\_\_

FAMILY HISTORY OF DEMENTIA: \_\_\_\_\_

ALCOHOL USE/HISTORY: \_\_\_\_\_

SMOKING USE/HISTORY: \_\_\_\_\_

ONSET AND PROGRESSION OF MEMORY PROBLEMS: \_\_\_\_\_

HOBBIES, INTERESTS OR OCCUPATIONAL SKILLS: \_\_\_\_\_

RECOGNITION: \_\_\_\_\_

REPETITION: \_\_\_\_\_

ANGRY OUTBURSTS/FRUSTRATION: \_\_\_\_\_

WANDERING: \_\_\_\_\_

OTHER INCIDENTS/BEHAVIOURS: \_\_\_\_\_

INTEREST IN SPEAKING WITH A MEMBER OF THE ALZHEIMER'S SOCIETY: \_\_\_\_\_

**JBN MEDICAL DIAGNOSTIC SERVICES INC.**

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## FUNCTIONAL AUTONOMY MEASUREMENT SYSTEM

PLEASE SELECT THE OPTION THAT BEST SUITS THE PATIENTS ABILITIES/FUNCTIONS.

<p><b>1. EATING:</b></p> <input type="checkbox"/> Feeds self independently <input type="checkbox"/> Feeds self independently with difficulty <input type="checkbox"/> Feeds self but needs stimulation/supervision <input type="checkbox"/> Needs some help to eat <input type="checkbox"/> Must be fed	<p><b>11. DONNING PROSTHESIS OR ORTHOSIS:</b></p> <input type="checkbox"/> Does not wear prosthesis or orthosis <input type="checkbox"/> Dons them independently <input type="checkbox"/> Dons them independently with difficulty <input type="checkbox"/> Donning of them needs checking <input type="checkbox"/> Must be put on by another person	<p><b>21. BEHAVIOUR:</b></p> <input type="checkbox"/> Appropriate behaviour <input type="checkbox"/> Minor behaviour problems-stubborn etc. <input type="checkbox"/> Major behaviour problems-aggression etc <input type="checkbox"/> Dangerous, required restraint
<p><b>2. WASHING:</b></p> <input type="checkbox"/> Washes self independently <input type="checkbox"/> Washes self independently with difficulty <input type="checkbox"/> Washes self but needs cueing/supervision <input type="checkbox"/> Needs help for daily wash but participates <input type="checkbox"/> Must be wash by another person	<p><b>12. PROPELLING A WHEELCHAIR:</b></p> <input type="checkbox"/> Does not need a wheelchair <input type="checkbox"/> Propels independently <input type="checkbox"/> Propels independently with difficulty <input type="checkbox"/> Needs to have wheelchair pushed <input type="checkbox"/> Unable to use a wheelchair (transported)	<p><b>22. HOUSEKEEPING:</b></p> <input type="checkbox"/> Does housekeeping alone <input type="checkbox"/> Does housekeeping alone with difficulty <input type="checkbox"/> Needs supervision for housekeeping <input type="checkbox"/> Needs help for daily housework <input type="checkbox"/> Does not do housework
<p><b>3. DRESSING:</b></p> <input type="checkbox"/> Dresses self independently <input type="checkbox"/> Dresses self independently with difficulty <input type="checkbox"/> Dresses self but needs cueing/supervision <input type="checkbox"/> Needs help dressing <input type="checkbox"/> Must be dressed by another person	<p><b>13. NEGOTIATING STAIRS:</b></p> <input type="checkbox"/> Goes up/down stairs alone <input type="checkbox"/> Goes up/down stairs alone with difficulty <input type="checkbox"/> Requires supervision/guidance <input type="checkbox"/> Needs help going up/down stairs <input type="checkbox"/> Does not negotiate stairs	<p><b>23. MEAL PREPARATION:</b></p> <input type="checkbox"/> Prepares own meals <input type="checkbox"/> Prepares own meals with difficulty <input type="checkbox"/> Needs supervision preparing meals <input type="checkbox"/> Only prepares light meals <input type="checkbox"/> Does not prepare meals
<p><b>4. GROOMING:</b></p> <input type="checkbox"/> Grooms self independently <input type="checkbox"/> Grooms self independently with difficulty <input type="checkbox"/> Grooms self but needs cueing/supervision <input type="checkbox"/> Needs help for grooming <input type="checkbox"/> Must be groomed by another person	<p><b>14. VISION:</b></p> <input type="checkbox"/> Sees adequately with/without Corrective lens <input type="checkbox"/> Visual problems, sees enough for ADLs <input type="checkbox"/> Only sees outlines of objects <input type="checkbox"/> Blind <input type="checkbox"/> Not had vision assessment in past yr	<p><b>24. SHOPPING:</b></p> <input type="checkbox"/> Plans & shops independently <input type="checkbox"/> Plans & shops independently with difficulty <input type="checkbox"/> Shops but needs delivery service <input type="checkbox"/> Needs help to plan or shop <input type="checkbox"/> Does not shop
<p><b>5. URINARY FUNCTION:</b></p> <input type="checkbox"/> Normal voiding <input type="checkbox"/> Occasional incontinence/dribbling <input type="checkbox"/> Needs cueing to avoid urinary incontinence <input type="checkbox"/> Frequent incontinence <input type="checkbox"/> Complete urinary incontinence	<p><b>15. HEARING:</b></p> <input type="checkbox"/> Hears adequately with/without hearing aid <input type="checkbox"/> Hears if spoken to in a loud voice <input type="checkbox"/> Only hears shouting <input type="checkbox"/> Deaf <input type="checkbox"/> Not had hearing assessment in past yr	<p><b>25. LAUNDRY</b></p> <input type="checkbox"/> Does laundry independently <input type="checkbox"/> Does laundry independently with difficulty <input type="checkbox"/> Needs supervision/cueing for laundry <input type="checkbox"/> Needs help with laundry <input type="checkbox"/> Does not do laundry
<p><b>6. BOWEL FUNCTION:</b></p> <input type="checkbox"/> Normal bowel function <input type="checkbox"/> Occasional incontinence <input type="checkbox"/> Needs cleaning or enema <input type="checkbox"/> Frequent incontinence <input type="checkbox"/> Always incontinent	<p><b>16. SPEAKING:</b></p> <input type="checkbox"/> Communicated only in prevailing language <input type="checkbox"/> Speech/language problem-able to express <input type="checkbox"/> Major speech/language problems <input type="checkbox"/> Unable to communicate verbally	<p><b>26. TELEPHONE:</b></p> <input type="checkbox"/> Uses telephone independently <input type="checkbox"/> Uses telephone with difficulty <input type="checkbox"/> Only dials a few numbers-emergency <input type="checkbox"/> Speaks but needs phone dialed/answered <input type="checkbox"/> Does not use phone
<p><b>7. TOILETING:</b></p> <input type="checkbox"/> Toilets self independently <input type="checkbox"/> Toilets self with difficulty <input type="checkbox"/> Needs supervision-toileting/uses commode <input type="checkbox"/> Needs help using toilet/commode <input type="checkbox"/> Does not use toilet/commode	<p><b>17. MEMORY:</b></p> <input type="checkbox"/> Normal memory <input type="checkbox"/> Minor recent memory deficits-recalls recent <input type="checkbox"/> Serious memory lapses—stove, meds <input type="checkbox"/> Almost total memory loss or amnesia	<p><b>27. TRANSPORTATION:</b></p> <input type="checkbox"/> Able to use transportation alone-bus/taxi <input type="checkbox"/> Able to use transportation with difficulty <input type="checkbox"/> Must be accompanied <input type="checkbox"/> Uses adapted vehicle, requires assistance <input type="checkbox"/> Must be transported in ambulance
<p><b>8. TRANSFERS:</b></p> <input type="checkbox"/> Gets in/out of bed alone <input type="checkbox"/> Gets in/out of bed alone with difficulty <input type="checkbox"/> Needs supervision/cueing- in/out of bed <input type="checkbox"/> Needs help getting in/out of bed <input type="checkbox"/> Bedridden (must be moved)	<p><b>18. ORIENTATION:</b></p> <input type="checkbox"/> Oriented to time, place, people <input type="checkbox"/> Sometimes disoriented to time, place, people <input type="checkbox"/> Only oriented to immediate events <input type="checkbox"/> Complete disorientation	<p><b>28. MEDICATION:</b></p> <input type="checkbox"/> Takes medication according to prescription <input type="checkbox"/> Takes medication with difficulty <input type="checkbox"/> Needs weekly supervision/dispenser <input type="checkbox"/> Needs to be prepared daily <input type="checkbox"/> Must be given each dose
<p><b>9. WALKING INSIDE:</b></p> <input type="checkbox"/> Walks independently (with/without cane etc) <input type="checkbox"/> Walks independently with difficulty <input type="checkbox"/> Walks independently but needs guidance <input type="checkbox"/> Needs help from another person to walk <input type="checkbox"/> Does not walk	<p><b>19. COMPREHENSION:</b></p> <input type="checkbox"/> Understands instructions/requests <input type="checkbox"/> Slow to understand instructions/requests <input type="checkbox"/> Partial understanding if instructions/requests <input type="checkbox"/> Requires repetition of instructions/requests <input type="checkbox"/> Unaware of what's going on around them	<p><b>29. BUDGETING:</b></p> <input type="checkbox"/> Manages budget independently <input type="checkbox"/> Manages budget with difficulty <input type="checkbox"/> Need supervision-major transactions <input type="checkbox"/> Needs help for regular transactions <input type="checkbox"/> Does not manage budget
<p><b>10. WALKING OUTSIDE:</b></p> <input type="checkbox"/> Walks independently (with/without cane etc) <input type="checkbox"/> Walks independently with difficulty <input type="checkbox"/> Walks independently but needs guidance <input type="checkbox"/> Needs help from another person to walk <input type="checkbox"/> Does not walk	<p><b>20. JUDGEMENT:</b></p> <input type="checkbox"/> Evaluated and makes sound decisions <input type="checkbox"/> Evaluates, needs help making sound decisions <input type="checkbox"/> Poorly evaluates and needs strong suggestion <input type="checkbox"/> Unable to evaluate or make a decision	<p><b>30. COMMENTS:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

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Last name:		First name:		
Sex:	Age:	Weight, kg:	Height, cm:	Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

## Screening

<p><b>A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?</b>          0 = severe decrease in food intake          1 = moderate decrease in food intake          2 = no decrease in food intake</p>	<input type="checkbox"/>
<p><b>B Weight loss during the last 3 months</b>          0 = weight loss greater than 3 kg (6.6 lbs)          1 = does not know          2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)          3 = no weight loss</p>	<input type="checkbox"/>
<p><b>C Mobility</b>          0 = bed or chair bound          1 = able to get out of bed / chair but does not go out          2 = goes out</p>	<input type="checkbox"/>
<p><b>D Has suffered psychological stress or acute disease in the past 3 months?</b>          0 = yes      2 = no</p>	<input type="checkbox"/>
<p><b>E Neuropsychological problems</b>          0 = severe dementia or depression          1 = mild dementia          2 = no psychological problems</p>	<input type="checkbox"/>
<p><b>F1 Body Mass Index (BMI) (weight in kg) / (height in m<sup>2</sup>)</b>          0 = BMI less than 19          1 = BMI 19 to less than 21          2 = BMI 21 to less than 23          3 = BMI 23 or greater</p>	<input type="checkbox"/>

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.  
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

<p><b>F2 Calf circumference (CC) in cm</b>          0 = CC less than 31          3 = CC 31 or greater</p>	<input type="checkbox"/>
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<p><b>Screening score</b> (max. 14 points)</p>	<input type="checkbox"/> <input type="checkbox"/>
<p><b>12-14 points:</b>      Normal nutritional status  <b>8-11 points:</b>      At risk of malnutrition  <b>0-7 points:</b>        Malnourished</p>	

Ref. Vellas B, Villars H, Abellan G, et al. *Overview of the MNA<sup>®</sup> - Its History and Challenges*. J Nutr Health Aging 2006;10:456-465.  
 Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. *Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF)*. J. Geront 2001;56A: M366-377.  
 Guigoz Y. *The Mini-Nutritional Assessment (MNA<sup>®</sup>) Review of the Literature - What does it tell us?* J Nutr Health Aging 2006; 10:466-487.

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For more information: [www.mna-elderly.com](http://www.mna-elderly.com)



# JBN Specialist Clinics

Internal Medicine - Critical Care – Respiriology – Geriatrics - Allergy – Immunology – Asthma - Bariatric Medicine  
Health Clinics - Clinical Research - Cardiac Diagnostics

Dr. W.A. Nisker Dr. J.C. Berlingieri Dr. M. Messieh Dr. M. Cyr

1. Name: \_\_\_\_\_
2. Do you have any **problems related to bone health**? No/Yes (please specify):  
\_\_\_\_\_
3. Are you on any **bone health medications**? No/Don't Know/Yes (please specify):  
\_\_\_\_\_
4. Age: \_\_\_\_\_ Sex: M/F
5. Height: \_\_\_\_\_ (ft, in/cm) Weight: \_\_\_\_\_ (lb/kg) BMI: \_\_\_\_\_

## Clinical Risk Factors

**For questions 6-12 (each question counts as 1 risk factor), add your risk factors up to determine your total number of Clinical Risk Factors (CRF)**

6. **Previous fracture (including compression fractures indicated on X-ray) or height loss since mid 20's of more than 2.5 in/6 cm (women) or 1.5 in/4 cm (men)?** No/Yes (location?):  
\_\_\_\_\_
7. **Parental hip fracture?** No/Yes (Mother/Father)
8. Current **smoker?** No/Yes
9. Any glucocorticoid use (either orally or as nasal sprays) (**Hydrocortisone (Cortisol)**/Cortisone acetate/**Prednisone/Prednisolone**/Methylprednisolone/Dexamethasone/Betamethasone/Triacinalone/Beclometasone/Fludrocortisone acetate/Deoxycorticosterone acetate (DOCA)/Aldersterone)? No/Yes (please specify): \_\_\_\_\_
10. **Rheumatoid arthritis (NOT OSTEOARTHRITIS)?** No/Yes
11. Do you have any of these conditions: **insulin dependent diabetes/osteogenesis imperfect/untreated long-standing hyperthyroidism/low sex hormone levels/menopause before age 45/chronic malnutrition/malabsorption/BMI<20/chronic liver disease?** No/Yes (please specify):  
\_\_\_\_\_
12. **3 or more units of alcohol per day** [1 unit equals one standard glass of beer (285mL, 9-10 oz), 1 shot of spirits (30mL, 1 oz), one medium glass of wine (120mL, 4 oz)]? No/Yes (please specify): \_\_\_\_\_

**Total Number of Clinical Risk Factors (CRF)? 0/1/2/3/4/5/6/7**

13. Have you had a **femoral neck** bone mineral density (BMD) **in the past year?** No/Not sure/Yes but do not know results/Yes (T-Score?): \_\_\_\_\_
14. **(Official use only, do not fill)**  
**10 year probability of osteoporotic fractures (please round age up and BMI down):** \_\_\_\_\_%