Southeast PA Dementia Screening Tool (DST)

also known as Dementia Screening Questionnaire for I /DD (adapted)*

DSQUIID (August 2007) adapted by Philadelphia Coordinated Health Care (PCHC) and SE PA Regional Dementia Task Force (2009, revised 2011) with clinical support provided by Carl V. Tyler Jr. MD, MS, CAQ-Geriatrics, CMD, Fairview Hospital/Cleveland Clinic

People with intellectual and developmental disabilities (I/DD) may be at risk for developing dementia/Alzheimer's Disease. This tool was developed to assist caregivers in collecting information to be shared with physicians. This is not a clinical assessment tool.

It is recommended that this tool:

- begin at age 35 for people with Down Syndrome
- begin at age 50 for people with Intellectual and Developmental Disabilities (I/DD), or earlier if symptoms are detected sooner
- once used be repeated on an annual basis or as often as needed
- be completed by someone who knows or works with the person for at least 6 months to a year
- be completed by multiple family members and/or various staff members

Name:

Date of Birth:

Female ☐ Male ☐

Diagnosis/Medical Conditions (include both Physical, i.e. Oral Health and Mental Health Conditions): **attach list if needed**

_____

_____

_____

_____

_____

_____

List Current Medications and dosages **or attach** Medication Administration Record:

_____

_____

_____

_____

_____

_____

_____

☐ Problem with vision/blind
☐ Problem with hearing/deaf
☐ Past Mental Health diagnosis (list)

_____ _____

Other Information

Any recent life changes? (e.g. death of family member or friend, loss, move, etc.)

_____

_____

Anything else worth noting?

_____

_____

**Dementia Screening Questionnaire for Individuals with Intellectual Disabilities (DSQIID), August 2007*
Professor Shoumitro Deb, MBBS, FRCPsych, MD, U.K. s.deb@bham.ac.uk

Southeast PA Dementia Screening Tool (DST)
Residential

Please complete the following questions by placing a check mark in the appropriate box. At the bottom of the paper, please detail your name, title, duration of experience with the client, time of observation of the client (AM, PM).

Example: Question 1) Cannot wash and or bathe without help.

- If the person has always needed help with washing and bathing in his or her adult life, please ☑ "Always been the case."
- If the person's previous skills in this area seem to have deteriorated, ☑ Always, ☐ but seems worse."
- If the person had the skill in their adult life and has recently lost this skill, please ☑ "New symptom."
- Finally, if the question does not apply to the person (in this case, if the person can wash without help and this has not changed), please ☑ "Does not apply."

	Always been the case (0)	**Always but worse (1)**	**New symptom (2)**	**Does not apply (0)**
Activities of Daily Living				
Cannot wash and/or bathe without help				
Cannot dress without help				
Dresses inappropriately (e.g., back to front, incomplete)				
Undresses inappropriately (e.g., in public)				
Needs help eating				
Needs help using the bathroom				
Incontinent (including occasional accidents)				
Language & Communication				
Does not initiate conversation				
Cannot find words				
Cannot follow simple instructions				
Cannot follow more than one instruction at a time				
Stops in the middle of a task				
Cannot read				
Cannot write (including printing own name)				
Sleep-Wake Pattern				
Excessive/inadequate (sleeping more or sleeping less)				
Wakes frequently at night				
Confused at night				
Sleeps during the day				
Wanders at night				
Ambulation				
Not confident walking over small cracks, lines on the ground or uneven surfaces				
Unsteady walk, loses balance				
Cannot walk unaided				

Southeast PA Dementia Screening Tool (DST)
Residential

	Always been the case (0)	Always but worse (1)	New symptom (2)	Does not apply (0)
Memory				
Cannot recognize familiar person (staff/relatives)				
Cannot remember names of familiar people				
Cannot remember recent events				
Cannot find way in familiar surroundings				
Loses track of time (time of day, day of the week, seasons)				
Behavior				
Wanders				
Withdrawal from social activities				
Withdraws from people				
Loss of interest in hobbies and activities				
Seems to go into own world				
Obsessive or repetitive behavior (e.g., empties cup-boards repeatedly)				
Hides or hoards objects				
Loses objects				
Puts familiar things into wrong places				
Does not know what to do with familiar objects				
Appears insecure				
Appears anxious or nervous				
Appears depressed				
Shows aggression (verbal or physical)				
Seizures				
Abnormal Involuntary Movement (head, neck, limbs, trunk)				
Talks to self				

Does the individual identify for himself/herself any change or loss of skill or abilities? (yes or no)
If so, what does he/she report?

_____

Please describe any other changes in behavior, personality, memory, or functional abilities?

_____

Date Completed:_____ Completed By:_____ Time Completed: _____	How long have you known the individual and in what capacity? _____ _____

Southeast PA Dementia Screening Tool (DST)
Day Program/Employer

	Always been the case (0)	Always but worse (1)	New symptom (2)	Does not apply (0)
Activities of Daily Living				
Cannot dress appropriately				
Incontinent (including occasional accidents)				
Language & Communication				
Difficulty finding words				
Memory				
Does not know location of areas (Bathroom,Workspace)				
Behavior				
Lack of interest with friends				
Lack of interest with hobbies				
Forgetful				
Sad				
Gets into fights or becomes argumentative easily				
Withdrawn				
Overly concerned (anxious)				
Job Performance				
Unable to complete routine tasks				
Difficulty learning new tasks				
Refusal to perform job				
Loses track of time/schedule/activities				
Academic				
Unaware of time by clock				
Unaware of time by association				
Unable to read				
Unable to write				
Medical				
Seizures				
Abnormal Involuntary Movement (head, neck, limbs, trunk)				
Ambulation difficulty				

Does the individual identify for himself/herself any change or loss of skill or abilities? (yes or no)
If so, what does he/she report?

_____

Please describe any other changes in behavior, personality, memory, or functional abilities?

_____

Date Completed:_____	How long have you known the individual and in what capacity?
Completed By: _____	_____
Time Completed:_____	_____