IPOS-Dem

Please write clearly

Person's name:...

Person's number …….

Date (dd/mm/yyyy):..

P11 **What have been the person's main problems <u>over the past week</u>?**

1...

2...

3...

D1 **What have been the family's or those important to them main concerns <u>over the past week</u>?**

1…….

2…….

3…….

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Please select <u>one box</u> that best describes how the person has been <u>affected</u> by each of the following symptoms <u>over the past week</u>.

		Not at all	*Slightly*	*Moderately*	*Severely*	*Over-whelmingly*	*Cannot assess*
P1	Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Shortness of breath	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Weakness or lack of energy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Nausea (feeling Like being sick/ vomiting)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Vomiting (being sick)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Poor appetite	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Constipation	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Dental problems or problems with dentures	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Sore or dry mouth	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Drowsiness (sleepiness)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Poor mobility (trouble walking, cannot leave bed, falling)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐

IPOS-Dem

		Not at all	Slightly	Moderately	Severely	Over-whelmingly	Cannot assess
P2	Swallowing problems (e.g. chokes, inhales food or drink, holds food in mouth)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Skin breakdown (redness, skin tearing, pressure damage)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Difficulty Communicating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Sleeping problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Diarrhoea	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Hallucinations (seeing or hearing things not present) and/or delusions (fixed false beliefs)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Agitation (restless, irritable)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P2	Wandering (as a result of distress or putting person at risk)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐

P2 **Has the person had any other symptoms? Please select one box to show how you feel each of these symptoms have <u>affected</u> the person <u>over the past week</u> (optional).**

	Not at all	Slightly	Moderately	Severely	Over-whelmingly	Cannot assess
1......................................	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
2......................................	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
3......................................	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐

IPOS-Dem

Over the past week:

		Not at all	*Occasionally*	*Sometimes*	*Most of the time*	*Always*	*Cannot assess*
P3	Has s/he been feeling anxious or worried?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P4	Have any of his/her family, or those important to them, been anxious or worried about the person?	***Not at all/ Not relevant*** ☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P7	Do you think s/he felt depressed?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
D2	Lost interest in things s/he would normally enjoy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐

Please turn over

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Over the past week:

		Always	Most of the time	Sometimes	Occasionally	Not at all	Cannot assess
P8	Do you think s/he felt at peace?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐
P6	Has s/he been able to interact positively with others (e.g. staff, family, residents)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐

Over the past week:

		Problems addressed/ No problems	Problems mostly addressed	Problems partly addressed	Problems hardly addressed	Problems not addressed	Cannot assess
P10	Have all practical problems been addressed? [e.g. hearing aids, foot care, glasses, diet]	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐

Who was involved in this assessment? Please tick all that apply

Person with dementia ☐ Keyworker ☐ Care team ☐ Family member(s) ☐ Health professional ☐

Other ☐ Please state ………