Date: _________________ Name: ____________________

Live Well At Home Rapid Screen

1.	Do you need help to do the following? a) Walking b) Getting out of bed/chair c) Going to the bathroom d) Bathing e) Dressing f) Eating *IF **2 OR MORE** CIRCLED → SCORE = 2*	☐
2.	During the last 6 months, have you had a fall that caused injuries? Yes No *NOTE: "Injuries" means fracture or joint dislocation, head injuries resulting in loss of consciousness and hospitalization, joint injuries that led to decreased activity, internal injuries that led to hospitalization OR 3 or more of any falls* *IF **YES** CIRCLED → SCORE = 2*	☐
3.	Do you have a family member/friend give you help because you need it? Yes No *IF **NO** CIRCLED → SCORE = 2*	☐
4.	Does your caregiver feel overwhelmed or stressed because of the care they provide you? Yes No *IF **YES** CIRCLED → SCORE = 2*	☐
5.	Have you thought about moving to other housing? Yes No 5a. If yes: where have you considered moving to?: *IF ANSWERED **"NURSING HOME"** OR **"ASSISTED LIVING"** (i.e., HOUSING WITH SERVICES) → SCORE = 2*	☐
6.	Do you live alone? Yes No *IF **YES** CIRCLED → SCORE = 1*	☐
7.	Do you or your family have concerns about your memory, thinking, or ability to make decisions? Are you: Very concerned Somewhat concerned Not concerned? *IF **VERY CONCERNED** CIRCLED → SCORE = 2* *IF **SOMEWHAT CONCERNED** CIRCLED → SCORE = 1*	☐
	TOTAL SCORE (SUM OF SCORES FOR ITEMS 1 THRU 7) =	☐

RISK CATEGORY:
0 = NO RISK; 1 = LOW RISK; 2 = MODERATE RISK; 3 and up = HIGH RISK

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Date: ____________ Name: ______________________ Proxy: _____________

Live Well At Home Proxy Rapid Screen

1.	Does <name of older person/NOP> need help from someone else to do the following? a) Walking b) Getting out of bed/chair c) Going to the bathroom d) Bathing e) Dressing f) Eating *IF **2 OR MORE** CIRCLED → SCORE = 2*	☐
2.	During the last 3 months, has NOP had a fall that caused injuries *or* engaged in behavior problems such as wandering, verbal or physical disruption, or other behaviors that require supervision? Yes No *NOTE: "Injuries" means fracture or joint dislocation, head injuries resulting in loss of consciousness and hospitalization, joint injuries that led to decreased activity, internal injuries that led to hospitalization OR 3 or more of any falls* *IF **YES** CIRCLED → SCORE = 2*	☐
3.	Does <NOP> have a family member/friend give help because she/he needs it? Yes No *IF **NO** CIRCLED → SCORE = 2*	☐
4.	(if cg) Do you feel overwhelmed or stressed because of the care you provide NOP? Yes No *IF **YES** CIRCLED → SCORE = 2*	☐
5.	Have you/NOP thought about moving NOP to other housing? Yes No 5a. If yes: where has NOP considered moving to?: *IF ANSWERED **"NURSING HOME"** OR **"ASSISTED LIVING"** (i.e., HOUSING WITH SERVICES) → SCORE = 2*	☐
6.	Does NOP live alone? Yes No *IF **YES** CIRCLED → SCORE = 1*	☐
7.	Do you or your family have concerns about NOP's memory, thinking, or ability to make decisions? Are you: Very concerned Somewhat concerned Not concerned? *IF **VERY CONCERNED** CIRCLED → SCORE = 2* *IF **SOMEWHAT CONCERNED** CIRCLED → SCORE = 1*	☐
	TOTAL SCORE (SUM OF SCORES FOR ITEMS 1 THRU 7) =	☐

RISK CATEGORY:
0 = NO RISK; 1 = LOW RISK; 2 = MODERATE RISK; 3 and up = HIGH RISK

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