SASH Assessment for PHL – Paper Version

Please use this paper version of the assessment for times when you cannot enter information directly into PHL.

New Referral = New SASH Participant **Fields with asterisk (*) are required, skip all others**	
Referral Source = SASH Panel	Panel will auto fill
***Referral Date** – will auto fill	
***Referral Program** (circle one)	SASH Full Benefit SASH Auto Benefit
***Referral Source Full Name**	Staff member logged in will auto-populate
***Referral Source Email**	Staff member logged in will auto-populate
Referral Source Phone	Skip
Referral Source Fax	Skip
Facility	Skip
Facility Phone	Skip
Room #	Skip
Diagnosis	Skip
Risk Factors	Skip
Case Manager First Name	Skip
Case Manager Last Name	Skip
Case Manager Phone	Skip
Case Manager Email	Skip
Client Identifier #	Skip
Client CBO #	Skip
***Client Name**	
Middle Name	
***Last Name**	
***Preferred Language**	
Primary Phone	
Secondary Phone	
Client Email	
Primary Contact Same as Above	Check this box to auto-populate Client Demographics
***Background/Notice Info for Immediate Follow-up**	**Required Field** Type “New Participant”
Fields below will appear at bottom of page after “Save Referral” is clicked	
Assign Date	Will auto-populate
Agency	SASH Panel
Staff Member	
Instructions	Okay to leave blank
Click “Show Client Window” after these fields are filled out	

See PHL User Instructions for next steps in a new referral process.

Client Tab: Demographics	
Client CBO#	Will auto-populate in PHL (= Patient ID#)
Company = SASH	SASH (Always = SASH)
First Name	
Middle Name	
Last Name	
Marital Status: (circle one)	Single Married Divorced Widowed Never Married Separated Living with Partner Never Married Other:_____
Gender: (circle one)	Male Female Transgender Other: _____

Race: (circle one)	American Indian or Alaska Native Native Hawaiian or other Pacific Islander	Black or African American Undetermined	Asian Other:_____	White
SSN			
Date of Birth			
Veteran	Yes No		
Spoken Language- Primary			
Signed Use and Disclosure	Yes No		
Date Signed			
Client Contact Info:			
Add Address:			
Address Type (circle one)	Home Mailing Other		
Address 1			
Address 2			
City			
State			
Zip			
Primary Address?	Yes No		
Add Phone:			
Phone Number			
Extension			
Primary Phone	Yes No		
Add Email:			
Email Type (circle one)	Personal Family Member Office Other		
Email Address			
Primary Email	Yes No		
Insurance:			
Insurance Number			
Insurance Type (circle all that apply)	Medicare	CHAMPUS	Self-Pay
	Medicare Supplemental (Medigap)	Cigna	TRICARE (armed forces)
	Medicare Plan C (Medicare Advantage)	Dental	Uninsured
	Medicare Part D	Fidelis	United Health Care
	Medicaid	Indian Health Services	Unknown
	AETNA	Long Term Care	VA Health System
	APEX	No Insurance Info	Vision
Contacts (contact person(s) details):			
First Name (of Contact)			
Middle Name			
Last Name			
Relationship to Participant (circle one)	Brother Daughter Daughter-in-law Friend Granddaughter Niece Son Son-in-law Niece Spouse Spouse Equivalent Neighbor Other:_____		
Power of Attorney (POA) circle all that apply:	Medical Financial Medical and Financial		
Guardian (circle one)	Yes No Pending Not Applicable		
HIPAA Consent	Yes No		
Primary	Yes No		
Gender (circle one)	Male Female Transgender Other: _____		
Disabled	Yes No		

Caregiver	Yes No
Household (Does this contact live in participant's home?)	
Active	Yes No

Contact Person(s) Info continued			
Address Type (circle one) Home Mailing Other			
Address 1			
Address 2			
City			
State			
Zip			
Primary Address info?		Yes No	
Phone Type (circle one) Home Mobile Work No phone service Other: _____			
Phone number			
Extension			
Primary Phone Info?		Yes No	
Email Type (circle one) Personal Family Member Office Other			
Email			
Primary Email Info?		Yes No	
Needs and Barriers Tab			
Services being provided (circle all that apply)	Area Agency on Aging	Food Assistance	Respiratory Therapy
	Case Management	Home Health Services	Speech Therapy
	Chronic Condition Management Support	Home Modifications	Substance Use Disorder Support
	Cognitive Health Support	Homemaker Services	Support Groups
	Dental Health	Legal	Tobacco Cessation
	Developmental Services	Medical	Transportation
	Disability Assistance	Mental Health Support	Utility Assistance
	Employment	None	Veteran Benefits
	CHAMPUS	Occupational Therapy	Volunteer Services
	End of Life Support	Personal Care Assistance	
	Financial	Physical Therapy	
Case Management Services (circle all that apply)	Choices for Care-Low Needs	Choices for Care-Moderate Needs	Choices for Care- High Needs
	Communication among providers insufficient	Disability Assistance	Eligibility- has not met
	Options/Benefit Counseling	Resources are at Capacity	Other:_____
Food (circle all that apply)	Daily Meal (Soup Kitchen)	Nutrition Education	SNAP (foodstamps)
	Donation	Eligibility- has not met	Voucher
	Holiday Assistance	Other:_____	
	Home Delivered Meals	Pantry	
Housing (circle all that apply) Subsidized Housing Rental Assistance Assisted Living Home Safety Assessment			
Home Modifications (circle all that apply)	CAPABLE	Limited mobility and/or ability to complete Activities of Daily Living	Ramp- permanent
	Grab bar(s)	Mobility Assessment	Ramp- Temporary
	Home Safety Assessment	Pest Control	Repair
Utility Assistance (circle all that apply) Electric Gas LIHEAP Water Other:_____			

Transportation (circle all that apply)	Daily errands	Medical (not dialysis)	Voucher
	Driver Safety	Volunteer	Other: _____
Medical (circle all that apply)	Addiction	Isolation	Physical Health
	Caregiver Support	Locate Pharmacy	Poor Prognosis
	Chronic Disease Management	Medical Diagnosis is unclear	Prescription Payment (not co-pay)
	Co-pay Assistance	Medication Review	Specialist
Medical (continued) (circle all that apply)	End of Life planning	Mental Health	Substance Abuse Therapist
	Hearing Deficit	No Primary Care Physician	Systems are not well managed
	Interpersonal Relationships	Past or Present Abuse/Trauma	Visual Deficit
Financial (circle all that apply)	Debt	Mortgage	Utility Assistance
	Financial Planning	POA- Financial	Other:
	Guardian	POA- Medical	
	Lack of computer/internet	Rental Assistance	
Legal (circle all that apply)	Adult Protective Services	Debt	POA- Financial
	Childcare Assistance	Elder Law Attorney	POA- Medical
	Child Protective Services	End of Life Planning	SSDI Attorney
	Criminal History	Guardian	Other:_____
Employment (circle all that apply)	Application Assistance	Part Time Employment	Veteran Employment
	Childcare Assistance	Resume Assistance	Vocational Rehabilitation
	Credential Programming	Second Job	Other:
	Full Time Employment	Senior Employment Program	
	Job Training Program	Unemployed Services	
Education (circle all that apply)	College	Language	Trade School
	GED	Literacy	None
VA Benefits		Yes No	
Notes:			

Goals and Objectives Tab

Goal Category (circle one)	Alcohol/ Drug use	Insurance/ Benefits	Social Support/relationships
	Budgeting/Finance	Legal	Spirituality
	Chronic Condition Education	Management of Health Conditions	Tobacco Cessation Support
	Dental	Medications/Medical Supplies	Transportation
	Education and/or Employment	Mental Health	Utilities
	Emergency Room Use	Pain Management	Volunteering/Comm. Serv.
	Exercise/ Physical Activity	Parent/Family Support	Weight Management
	End of Life Support	Provider Relationships	Other:
	Food and Nutrition	Recreation Activities	
	Housing Assistance	Safety	
Specific Goal (type in):			
Status (circle one)	New Review Achieving Interrupt Modified		

	Partially Complete Complete Future Goal		
Primary Goal		Yes No	
Objective		Select- "Describe Specific Objective"	
Objective Notes (Type in)			
Objective Status (circle one)	New Review Achieving Interrupt Modified Partially Complete Complete Future Goal		
Primary Objective		Yes No	

Immunizations Tab			
Immunization	**Status (circle one)**	**Approximate Date**	**Comments**
Influenza	Yes No Unknown No-Med		
Pneumovax	Yes No Unknown No-Med		
Prevnar	Yes No Unknown No-Med		
Shingles	Yes No Unknown No-Med		
Other:_____	Yes No Unknown No-Med		
Other:_____	Yes No Unknown No-Med		

Visit Tab – Visit Details			
***Select Service/ Program**		SASH Full Benefit	SASH Auto Benefit
Select Service to View SDP Information		Skip	
***Referral Date**		Will auto-populate	
*Visit Type (circle one)	Group Program	Person Centered Interview	SASH Coordinator Home Visit
	Exit Program	Phone call/communication	Wellness Nurse Home Visit
Visit Reason (circle all that apply)	Care Coordination	Health Coaching	Reassessment
	Caregiver/Family Support	Healthy Living Plan	Transitions of Care
	CDSMP Class	Initial Assessment	Social Group Program
	Exercise Group Program	Medication Reconciliation	WN Group Program
	Family outreach/support	No longer in SASH/Panel	Blood Pressure Clinic
*Visit Coordinator		Staff Member logged in will auto-populate	
Click "Save Visit" at bottom and the rest of the tabs will become accessible			

SASH Coordinator Assessment Tab			
Is the participant living in the community at large?		Yes No ("no" if living at a hub site, "yes" if living Elsewhere)	
Do you have a documented Advance Directive?		Yes No	
If no, would you like assistance creating an Advance Directive?		Yes No Not Now NA	
Advance Directive Agent's Contact Information			
Where is Advance Directive stored? (circle all that apply)		Family Member Home MD Office NA Vermont Advance Directives Registry Other:_____	
Does participant need a referral for additional services?		Yes No NA	
Reason for Referral (circle one/select one from dropdown)	Asthma	Health Maintenance	Other Social Support Srvc
	Case Management	Healthier Living Workshop	Palliative Care
	Dental Health	Home Care Service	Physical Activity Assistance

	Diabetes	Housing Assistance	Substance Abuse Treatment
	Employment Assistance	HTN Management	Tobacco Cessation
	Family Wellness	Insurance Assistance	Transportation assistance
	Financial Assistance	Medication Assistance	Volunteer Services
	Food Assistance	Mental Health	Other:
	Health Education	Nutrition Clinician	
Agency Referred to	Area Agency on Aging	Other:_____	Transportation Agency
	Community Health Team	NA	802 Quits
	Community Mental Health Agency	Home Health Agency	Other:
	Quit Now RI	Primary Care Provider	
Specify "Other" reason for referral (if applicable, if not indicated with "NA"):			
Does Participant use an assistive device for ambulation?		Yes No	
Select Assistive Device used primarily: Cane Walker Crutches Wheelchair Motorized Scooter NA			
Does participant need any of the following (circle all that apply)	Ramp	Assistive Dressing Devices	Other:
	Doorways Widened	Kitchen/Bathroom modifications	
	Assistive Eating Devices	None of the above	
Does the participant need assistance obtaining any of the following (circle all that apply)	Eyeglasses	Dentures	Other:
	Hearing Aids	None	
Does the participant have a Personal Emergency Response System (PERS) such as Lifeline or Link to Life?		Yes No	
Mode of Transportation (circle one): Car Bus Support Person Transportation Agency Bike Other:_____			
Notes:			
General Health Assessment Tab			
How does the participant rate their health? Excellent Very Good Good Fair Poor Not Done			
Do you Routinely have an annual exam?		Yes No NA	
Does the participant need assistance managing medications?		Yes No	
Do you take care of your own feet/toenails?		Yes No	
If not, who does?			
Foot Conditions	Calluses	Bunions	Dry Skin
	Corns	Fungus	NA
	Cuts	Overgrown Toenails	
	Bruises	Ingrown Toenails	
How many days a week do you get a total of 30 minutes or more of physical activity? (enough to raise your breathing rate) (circle one)		0 1 2 3 4 5 6 7	
Have you suffered a personal loss or misfortune in the last year (ex. Job loss, disability, divorce, death of someone close)		No Yes, one serious loss Yes , two or more serious losses	
GAD 2 Anxiety Screening: over the past two weeks how often have you been bothered by feeling nervous, anxious, or on edge (circle one)		0 – Not at all 2 – more than half the days 1 – Several days 3 – Nearly everyday	

GAD 2 Anxiety Screening: over the past two weeks how often have you been bothered not being able to stop or control worrying (circle one)	0 – Not at all 2 – more than half the days 1 – Several days 3 – Nearly everyday ***If total score from two questions is 3 or higher please continue on to GAD 7**
Have you wished you were dead or wished that you could go to sleep and not wake up?	Yes No **If "Yes" complete the Columbia Suicide Severity Rating Scale (C-SSRS)**
Do you sometimes drink beer, wine, or other alcoholic beverages?	Yes No **If "Yes" continue to next question**
How many times in the past year have you had 4 or more drinks in a day?	1 time 2 times 3 or more times None **If answer is 2 or 3 or more, continue to S-MAST-G (or Audit if under 60 years of age.)**
How many times in the past year have you used an illegal drug or used a prescribed med for non-medical reasons?	0 times 1 time 2 times 3 or more times None **If answer is 1 or greater continue to DAST-10**
What is your current relationship with tobacco (circle one)	Never Former Current Tobacco User Currently exposed to second hand smoke No for medical reasons Not Performed
Would you like assistance with Tobacco Cessation?	Yes No Not Now NA
Care Utilization Tab This will auto-populate from Patient Ping in the near future and is okay to skip now	
Care Utilization Type (circle one)	Inpatient ED Outpatient Rehab/SNF Long Term Care
Admit Date	
Discharge Date	
Facility (name of hospital)	
Transportation	Yes No NA
Notes:	
Clinician Tab	
Clinician Name (first name, last name)	
Practice: (select from drop down)	
Phone	
Fax	
Email	
Address	
Primary Care Provider	Check box. Check if = yes
Specialist	Check box. Check if = yes
Specialty: (select from drop down)	
Notes	
Do you like visiting your doctor?	Yes No NA
Would you rather visit another doctor?	Yes No NA
Diagnosis Tab	
ICD 10 Code	**DO NOT USE – SKIP**
ICD 10 Name/Description	**DO NOT USE – SKIP**

Non-Clinical Diagnosis (Chronic Conditions) select from drop down in PHL

Heart/Circulation	Cancer	Deep Vein Thrombosis	Heart Disease
	Anemia	Pulmonary Embolus	Pre-Hypertension

	Atrial Fibrillation or other Dysrhythmias (bradycardias and tachycardia)	Pulmonary Edema	Hypertension
	Coronary Artery Disease (angina, myocardial infarction, atherosclerotic heart disease)	Peripheral Vascular Disease	Pacemaker/ Implantable Cardiac Defibrillator
Gastrointestinal	Cirrhosis	Diverticulitis	Irritable Bowel Syndrome
	Ulcer (esophageal, gastric, and peptic ulcers)	Liver Disease	
	GERD or Acid Reflux	Crohn's Disease	
Genitourinary	Benign Prostatic Hyperplasia	Renal Failure	Neurological Bladder
	Renal Insufficiency	End Stage Renal Disease	Obstructive Uropathy
Infections	Multi-drug resistant organisms	Tuberculosis	Wound Infection (other than foot)
	Pneumonia	Urinary Tract Infection	
	Septicemia	Viral Hepatitis	
Metabolic and Endocrine	Diabetes Mellitus	Hyponatremia	Hyperlipidemia
	Pre-Diabetes	Hyperkalemia	Thyroid Disease
Musculoskeletal	Arthritis Osteoporosis Hip Fracture Other Fracture		
Neurological	Alzheimer's Disease	Non-Alzheimer's Dementia	Huntington's Disease
	Aphasia	Hemiplegia	Parkinson's Disease
	Cerebral Palsy	Hemiparesis	Tourette's Syndrome
	Cerebrovascular Accident	Paraplegia	Seizure Disorder
	Transient Ischemic Attack	Quadriplegia	Epilepsy
	Stroke	Multiple Sclerosis	Traumatic Brain Injury
Nutritional	Malnutrition Risk for Malnutrition		
Psychiatric Mood Disorders	Anxiety Disorder	Manic Depression (bipolar)	Schizophrenia
	Depression	Psychotic Disorder	Post-Traumatic Stress Disorder
Addiction	Nicotine Alcohol Abuse Drugs		
Sleep Disorder	Insomnia Sleep Apnea		
Pulmonary	Asthma	Chronic Lung Disease (chronic bronchitis and restrictive lung diseases such as asbestosis	Respiratory Failure
	Chronic Obstructive Pulmonary Disorder		
Sensory	Hearing Impairment		
Vision	Cataracts Glaucoma Macular Degeneration General Visual Decline		
Other	Chronic Pain	Obesity	Other:_____
Effective State Date of DX code (can skip unless new DX)			
Effective End Date of DX Codes			
Date of Onset/Exacerbation			
Clinician		Select from drop down of participant's own physician's previously entered	
Questions this client has about their diagnosis			
Would this client like a consult about their diagnosis		Yes No	
Would this client like to get another option about their diagnosis from another clinician?		Yes No	

Medication Tab						
Medication Name	Strength	Units	Dosage Frequency	Dosage Number	Dosage Method	Special Instructions

Medication Compliance Status – Patient (check all that apply per medication) write name of med in right column	
Caregiver issues	
Client refuses to take	
Distrusts prescribing clinician	
Doesn't think it works	
Expired/discontinued still taking	
Fearful of taking as prescribed	
Feels better stopped taking	
Prescription not filled	
PRN (as needed)	
Side effects	
Substituting for another drug	
Taken as prescribed	
Transportation issue	
Unable to pay	
Unable to self-dose	
Other	

Med. Compliance Status – Systems level (check all that apply per medication) write name of med in right column	
Prescribed with known allergies/intolerances	
Conflicting information from different informational sources	
Discharge instructions incomplete/inaccurate/illegible	
Duplicate prescription	
Incorrect dosage	
Incorrect quantity	
Other	

Incorrect label	
Cognitive impairment not recognized by prescriber	
No caregiver/needs for assistance with medication not recognized	
Sight/dexterity limitations not recognized	
None	
Other	
Prescribing provider	Select from drop down of participant's own physician's previously entered
Prescribed on date okay to skip if unknown	
Expected to refill date okay to skip if unknown	
Dispensing pharmacy	
Pharmacy notes	
Client would like to consider an alternate medication if available	Yes No
Client would like additional information about why they are taking this medication	Yes No
Medication Notes:	

Allergies Tab
Allergy Name (select from a drop down)
Allergy Notes:
Intolerance Name:
Intolerance Notes:

Vitals Tab	
Blood Pressure Sitting (systolic diastolic)	
Heart Rate	
Blood Pressure Supine (systolic diastolic)	
Weight (lbs.)	
Height (inches)	
BMI (calculated automatically)	
Temperature	
Pain (select from a drop down)	
A1C Number	
Oxygen Saturation %	
Home Blood Glucose	
Edema (select from drop down)	
Respiratory rate	
Vitals Notes:	

Physical Self-Maintenance Scale (PSMS)Tab: Activities of Daily Living (circle one)		
Toileting Hygiene	Independent	Needs Assistance
Feeding or Eating	Independent	Needs Assistance
Dressing Upper Body	Independent	Needs Assistance
Dressing Lower Body	Independent	Needs Assistance

Grooming	Independent	Needs Assistance
Bathing	Independent	Needs Assistance
Toilet Transferring	Independent	Needs Assistance
Transferring	Independent	Needs Assistance
Ambulation/Locomotion	Independent	Needs Assistance
Instrumental Activities of Daily Living Tab (circle one)		
Telephone	Independent	Needs Assistance
Traveling	Independent	Needs Assistance
Shopping	Independent	Needs Assistance
Preparing Meals	Independent	Needs Assistance
Housework	Independent	Needs Assistance
Medications	Independent	Needs Assistance
Money	Independent	Needs Assistance
Patient Health Question (PHQ 2) (circle one) **Over the past two weeks how often have you been bothered by any of the following problems?**		
Little interest or pleasure in doing things	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Feeling down, depressed, or hopeless	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Add point value for each question answered above, if total point are 3 or greater, complete the full PHQ-9		
Patient Health Question (PHQ 9) (circle one) **Over the past two weeks how often have you been bothered by any of the following problems?**		
Little interest or pleasure in doing things	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Feeling down, depressed, or hopeless	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Trouble falling asleep, staying asleep, or sleeping too much	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Feeling tired or having little energy	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Poor appetite or overeating	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Trouble concentrating on things such as reading the newspaper or watching television	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Thinking that you would be better off dead or that you want to hurt yourself in some way	0-Not at all 2-More than half the days	1- Several Days 3- Nearly everyday
Total will auto-calculate in PHL 0-4=minimal depression, 5-9= mild, 10-14 moderate, 15-19=moderately severe, 20-17 severe		
If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all very difficult	somewhat difficult extremely difficult
Nutrition Assessment (total will auto-calculate in PHL) *What you eat does affect your health. Use this checklist to find out if you or someone you know is at nutritional risk.*		

Have you made any changes in lifeline eating habits because of health problems?	Yes No
Do you eat fewer than two meals a day?	Yes No
Do you eat fewer than five services (1/2 cup each) of fruits and vegetables every day?	Yes No
Do you eat fewer than two servings of dairy products (such as mile, yogurt, or cheese) every day?	Yes No
Do you sometimes not have enough money to buy food?	Yes No
Do you have trouble eating due to problems with biting/ chewing / swallowing?	Yes No
Do you eat alone most of the time?	Yes No
Without wanting to, have you lost or gained ten pounds in the last 6 months?	Yes No
Are you not always physically able to shop, cook, and/or feed yourself (or get someone to do it for you?)	Yes No
Do you have three or more drinks of beer, liquor, or wine almost every day?	Yes No
Do you take three or more prescriptions or over-the-counter drugs per day?	Yes No

Falls Risk Assessment Tab (total score will auto-calculate and show in PHL)

Question	Why it matters	Answer
I have fallen in the past year.	People who have fallen once are likely to fall again.	Yes No
I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.	Yes No
Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.	Yes No
I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.	Yes No
I am worried about falling.	People who are worried about falling are more likely to fall.	Yes No
I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.	Yes No
I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.	Yes No
I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.	Yes No
I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.	Yes No
I take medicine that sometimes make some feel lightheaded or more tired than usual.	Side effects from medicines can sometimes increase you a chance of falling.	Yes No
I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.	Yes No
I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.	Yes No

Falls History Tab	
Approximate date of most recent fall	
Cause of most recent fall	
Disposition of most recent fall (circle all that apply)	ED visit Hospital Stay NA Other:_____
Social Connectedness (Lubben Social Network Scale and UCLA Loneliness Scale) *Social Isolation is a state of complete or near complete lack of contact between an individual and society. Loneliness reflects a temporary lack of contact with other humans. Research shows both relate to mortality and negative health outcomes. Below is a social isolation and a loneliness scale. Please complete both with each participant at their annual assessment. You may reassess as needed. Lubben Social Network Scale: specifically designed for elderly adult. Results of the scale have correlate with mortality, hospitalization, health behaviors, depressive symptoms, and overall physical health. The score shows in PHL. A score of less than 12 points is suggestive of social isolation. UCLA Loneliness Scale: three-question measure to look at the dimensions of loneliness including relational connectedness, social connectedness, and perceived isolation. The scores of each individual question can be added together to give range of scores from 3 to 9. Researches have grouped people who score 3-5 as "not lonely" and people with a score of 6-9 as "lonely."*	
Lubben Social Network Scale: (circle one) total will auto-calculate in PHL (12 or greater suggestive of social isolation)	
How many relatives do you see or hear from at least once a month?	0-None 1-One 2-Two 3-Three or four 4-Five through eight 5-Nine or more Not Performed
How many relatives do you feel at ease with that you can talk about private matters?	0-None 1-One 2-Two 3-Three or four 4-Five through eight 5-Nine or more Not Performed
How many relatives do you feel close to such that you could call on them for help?	0-None 1-One 2-Two 3-Three or four 4-Five through eight 5-Nine or more Not Performed
How many of your friends do you see or hear from at least once a month?	0-None 1-One 2-Two 3-Three or four 4-Five through eight 5-Nine or more Not Performed
How many friends do you feel at ease with that you can talk about private matters?	0-None 1-One 2-Two 3-Three or four 4-Five through eight 5-Nine or more Not Performed
How many friends do you feel close to such that you could call on them for help?	0-None 1-One 2-Two 3-Three or four 4-Five through eight 5-Nine or more Not Performed
UCLA Loneliness Scale: (circle one) total will auto-calculate in PHL (3-5=not lonely, 6-8=lonely)	
How often do you feel that you lack companionship?	Hardly ever (1) Some of the time (2) Often (3) Not performed
How often do you feel left out?	Hardly ever (1) Some of the time (2) Often (3) Not performed
How often do you feel isolated from others?	Hardly ever (1) Some of the time (2) Often (3) Not performed
Mini Cog Tab *Start the cognitive assessment by having the participant repeat the following 3 words right after you say them: Telephone, umbrella, flowers. This is to make sure they heard and understood the words correctly Then move on to the next time. Provide a blank piece of paper to the participant and ask them to do the following steps: "First, draw the face of a clock and put all of the numbers on it. Make it large. Now, draw the hands, point at 20 minutes before 4 O'clock, Good." Keep the clock drawing. When the clock drawing is complete, ask the participant, "Please tell me the three words I asked you to remember earlier." Next, is the category fluency, please make sure you have a timing device available. Say, "When I tell you to start, please name as many kinds of animals as you can think of in one minute. Ok?" When the person is ready. Say, "begin" and start the timer. At the end of 60 seconds stop the timer and say, "Ok, that's good. Thank you." Keep track of how many animals they named, (which animal is not important).*	
Clock Drawing	5-7 points = passing score 4 points = borderline 0-3 points = failing score
Three Word Recall	3 points = passing score 2 points = borderline

	1-0 points = failing score
Category Fluency	>15 animals named within the one minute= passing score 15 animals = borderline <15 animals = failing score
Total Cognitive Ability Score: Pass/Fail	Pass Fail
Participant is unable to perform the cognitive screen	Yes No
Additional information about cognitive assessment:	
GAD 7 Tab (Over the past two weeks how often have you…) circle one *Score: total points from all GAD Answers 5-9 Mild Anxiety, 10-14 Moderate Anxiety, 15 + Severe Anxiety*	
Been bothered by feeling nervous, anxious, or on edge?	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Been bothered by not being able to stop or control worrying	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Worrying too much about different things	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Trouble relaxing	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Being so restless that it is hard to sit still	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Becoming easily annoyed or irritable	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Feeling afraid as if something awful might happen	0-Not at all 1-Several Days 2-Over Half of the Days 3-Nearly Every Day
Total will auto-calculate in PHLB (5-9 mild anxiety, 10-14 moderate anxiety, 15+ severe anxiety)	
If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all somewhat difficult very difficult extremely difficult
S-MAST-G Tab (circle one) total will auto-populate in PHL *Two or more "yes" answers indicate the need for a brief intervention and possibly referral for assessment and treatment.*	
When talking to others, do you ever understate how much you actually drink?	Yes No
When drinking, have you sometimes skipped a meal because you did not feel hungry?	Yes No
Does having a few drinks help reduce shakiness or tremors?	Yes No
Does alcohol sometimes make it hard for you to remember parts of a day or night?	Yes No
Do you usually take a drink to relax or calm your nerves?	Yes No
Do you drink to take your mind off problems like feeling alone or being in physical or emotional pain?	Yes No
Have you increased your drinking after experiencing a loss in your life?	Yes No
Has a doctor, nurse, or other health care provider ever said that they were concerned about your drinking?	Yes No
Have you tried to reduce your drinking from your own concern or to try and manage the amount of your drinking?	Yes No
When you feel lonely does having a drink help you feel better?	Yes No

Do you drink alcohol and a the same time use mood or mind altering drugs, including prescription, tranquilizers, prescription sleeping pills, prescription pain pills, or illicit drugs?	Yes No
Notes:	

Audit Tab (circle one) total will auto-populate in PH (0-7=low risk, 8-15=risky level, 16-19 hazardous level, 20 and above=high level)	
How often do you have a drink containing alcohol?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
How often do you have 5 or more drinks in one occasion?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
How often during the last year, have you found that you were not able to stop drinking once you had started?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
How often during the last year, have you failed to do what was normally expected of you because of drinking?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
How often during the last year, have you had a feeling of guild or remorse after drinking?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
How often during the last year, have you been unable to remember what happened the night before because of your drinking?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
Have you or someone else been injured because of your drinking?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	0=Never 1=less than monthly 2=2-4 times a month 3=2-3 times a week 4=4 or more times a week
Notes:	

DAST-10

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months. When the words "drug abuse" are used, they mean the use of prescribed or over the counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco. If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section. Scoring: 1point for each "yes" 0- no problems reported- none at this time, 1-2 low level- monitor, re-assess at a later date, 3-5 Moderate level – Further Investigation, 6-8 Substantial level – intensive assessment, 9-10 severe level, intensive assessment.

Have you used drugs other than those required for medical reasons?	Yes No
Do you abuse more than one drug at a time?	Yes No
Are you always able to stop using drugs when you want to? (if never use drugs, answer “yes.”)	Yes No
Have you had “blackouts” or “flashbacks” as a result of drug use?	Yes No
Do you ever feel bad or guilty about your drug use? (if never use drugs, choose “no.”)	Yes No
Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
Have you neglected your family because of your use of drugs?	Yes No
Have you engaged in illegal activities in order to obtain drugs?	Yes No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes No
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes No

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime Recent - Clinical

Version 1/14/09

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

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SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

	Most Severe	Most Severe
Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*) Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)		
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____	**Yes** ☐ **No** ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____