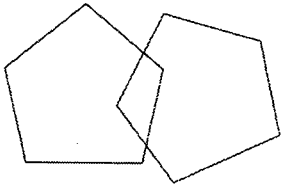


STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE)

	QUESTION	TIME ALLOWED	SCORE
1	a. <i>What year is this?</i>	10 seconds	/1
	b. <i>Which season is this?</i>	10 seconds	/1
	c. <i>What month is this?</i>	10 seconds	/1
	d. <i>What is today's date?</i>	10 seconds	/1
	e. <i>What day of the week is this?</i>	10 seconds	/1
2	a. <i>What country are we in?</i>	10 seconds	/1
	b. <i>What province are we in?</i>	10 seconds	/1
	c. <i>What city/town are we in?</i>	10 seconds	/1
	d. <i>IN HOME – What is the street address of this house?</i> <i>IN FACILITY – What is the name of this building?</i>	10 seconds	/1
	e. <i>IN HOME – What room are we in? IN FACILITY – What floor are we on?</i>	10 seconds	/1
3	<i>SAY: I am going to name three objects. When I am finished, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Say the following words slowly at 1-second intervals - ball/ car/ man</i>	20 seconds	/3
4	<i>Spell the word WORLD. Now spell it backwards.</i>	30 seconds	/5
5	<i>Now what were the three objects I asked you to remember?</i>	10 seconds	/3
6	<i>SHOW wristwatch. ASK: What is this called?</i>	10 seconds	/1
7	<i>SHOW pencil. ASK: What is this called?</i>	10 seconds	/1
8	<i>SAY: I would like you to repeat this phrase after me: No ifs, ands or buts.</i>	10 seconds	/1
9	<i>SAY: Read the words on the page and then do what it says. Then hand the person the sheet with CLOSE YOUR EYES on it. If the subject reads and does not close their eyes, repeat up to three times. Score only if subject closes eyes</i>	10 seconds	/1
10	<i>HAND the person a pencil and paper. SAY: Write any complete sentence on that piece of paper. (Note: The sentence must make sense. Ignore spelling errors)</i>	30 seconds	/1
11	<p><i>PLACE design, eraser and pencil in front of the person. SAY: Copy this design please.</i></p>  <p>Allow multiple tries. Wait until person is finished and hands it back. Score only for correctly copied diagram with a 4-sided figure between two 5-sided figures.</p>	1 minute	/1
12	<p><i>ASK the person if he is right or left-handed. Take a piece of paper and hold it up in front of the person. SAY: Take this paper in your right/left hand (whichever is non-dominant), fold the paper in half once with both hands and put the paper down on the floor. Score 1 point for each instruction executed correctly.</i></p> <p style="text-align: right;">Takes paper correctly in hand Folds it in half Puts it on the floor</p>	30 seconds	/1 /1 /1
TOTAL TEST SCORE			/30

Note: This tool is provided for use in British Columbia with permission by Dr. William Molloy. This questionnaire should not be further modified or reproduced without the written consent of Dr. D. William Molloy.

GLOBAL DETERIORATION SCALE (GDS)

Stage	Deficits in cognition and function	Usual care setting
1	Subjectively and objectively normal	Independent
2	<ul style="list-style-type: none"> • Subjective complaints of mild memory loss. • Objectively normal on testing. • No functional deficit 	Independent
3	Mild Cognitive Impairment (MCI) <ul style="list-style-type: none"> • Earliest clear-cut deficits. • Functionally normal but co-workers may be aware of declining work performance. • Objective deficits on testing. • Denial may appear. 	Independent
4	Early dementia <ul style="list-style-type: none"> • Clear-cut deficits on careful clinical interview. Difficulty performing complex tasks, e.g. handling finances, travelling. • Denial is common. Withdrawal from challenging situations. 	Might live independently – perhaps with assistance from family or caregivers.
5	Moderate dementia <ul style="list-style-type: none"> • Can no longer survive without some assistance. • Unable to recall major relevant aspects of their current lives, e.g. an address or telephone number of many years, names of grandchildren, etc. Some disorientation to date, day of week, season, or to place. They require no assistance with toileting, eating, or dressing but may need help choosing appropriate clothing. 	At home with live-in family member. In seniors' residence with home support. Possibly in facility care, especially if behavioural problems or comorbid physical disabilities.
6	Moderately severe dementia <ul style="list-style-type: none"> • May occasionally forget name of spouse. • Largely unaware of recent experiences and events in their lives. • Will require assistance with basic ADLs. May be incontinent of urine. • Behavioural and psychological symptoms of dementia (BPSD) are common, e.g., delusions, repetitive behaviours, agitation. 	Most often in Complex Care facility.
7	Severe dementia <ul style="list-style-type: none"> • Verbal abilities will be lost over the course of this stage. • Incontinent. Needs assistance with feeding. • Loses ability to walk. 	Complex Care

Adapted by Dr. Doug Drummond from Reisberg B, Ferris SH, Leon MJ, et al. The global deterioration scale for assessment of primary degenerative dementia. *American Journal of Psychiatry* 1982;139:1136-1139.