F5342

mater health

TRANSDISCIPLINARY INITIAL NEUROLOGICAL SCREENING ASSESSMENT (TINSA)

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

Admitting diagnosis/investigations:

History of presenting condition:

Medical history:

Assessment completed with:

Social History

Living arrangement: ☐ Alone ☐ Partner/Family ☐ Other:

Carer role: ☐ Provides care ☐ Receives care ☐ Suspected carer stress

Details (who/how much support):

Formal services: ☐ Yes ☐ No Details:

☐ **Refer to SW** (e.g. lack of support, complex social situation, suspected carer stress, advanced care planning)

Previous Level of Function and Activity Participation

Occupation: ☐ Full-time ☐ Part-time ☐ Retired Details:

Education level:

Mobility/transfers:	☐ Independent	☐ SBA	☐ Assist	
Falls in last 12 months:	☐ Yes ☐ No	Reason:		
Eating/diet:	☐ Independent	☐ SBA	☐ Assist	(normal/modified; dentition)
Toileting/continence:	☐ Independent	☐ SBA	☐ Assist	
Dressing:	☐ Independent	☐ SBA	☐ Assist	
Showering:	☐ Independent	☐ SBA	☐ Assist	
Meal prep:	☐ Independent	☐ SBA	☐ Assist	
Shopping:	☐ Independent	☐ SBA	☐ Assist	
Cleaning:	☐ Independent	☐ SBA	☐ Assist	
Laundry:	☐ Independent	☐ SBA	☐ Assist	
Gardening:	☐ Independent	☐ SBA	☐ Assist	
Medication:	☐ Independent	☐ SBA	☐ Assist	
Finances:	☐ Independent	☐ SBA	☐ Assist	
Driving:	☐ Yes ☐ No	Alternate transport:		

Leisure/exercise regime:

Home Environment

Housing: ☐ House ☐ Unit ☐ Townhouse ☐ Retirement village ☐ RACF ☐ Other:

Ownership: ☐ Owner ☐ Rented ☐ Department of Housing ☐ Other:

Stairs: _____ Front – rails ascending: ☐ Left ☐ Right _____ Back – rails ascending: ☐ Left ☐ Right

_____ Internal – rails ascending: ☐ Left ☐ Right _____ Side – rails ascending: ☐ Left ☐ Right

Ground level rooms:

Upstairs rooms:

Bathroom: ☐ Shower recess ☐ Bath ☐ Shower over bath ☐ Hob ☐ Rails ☐ HHSH ☐ FSH ☐ Door ☐ Curtain

☐ Equipment:

Toilet: ☐ In bathroom ☐ Separate ☐ Rails ☐ Equipment:

Other equipment: Personal alarm: ☐ Yes ☐ No

Previous OT home visit: ☐ Yes ☐ No If YES, details:

Cognition

Documented/reported history of cognitive impairment? ☐ Yes ☐ No If YES, details:

MSQ: _____ **/10** ☐ Day ☐ Date ☐ Month ☐ Year ☐ DOB ☐ Age ☐ Address ☐ Location ☐ PM ☐ PPM

Insight into deficits: ☐ Yes ☐ Partial ☐ No

Comments:

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Communication

Hearing aids? ☐ Nil ☐ Left ☐ Right ☐ ALD required Primary language: .....

Has your speech changed recently (e.g. slurred)? ☐ Yes ☐ No

If YES, details: .....

New difficulties thinking of words, reading, writing, understanding what people say? ☐ Yes ☐ No

If YES, details: .....

Have your family/friends noticed any changes with your communication/language? ☐ Yes ☐ No

If YES, details/changes: .....

Informal communication screen

Observations: language in conversation	☐ Level 1 = Normal language ☐ Level 2 = Able to speak in sentences but word finding difficulties evident ☐ Level 3 = Speaking only in single words or short phrases – can communicate basic needs/wants ☐ Level 4 = Very limited or no verbal output – unable to communicate basic needs/wants ☐ Level 5 = Nonsensical or no verbal output – unable to communicate basic needs/wants
Naming/word retrieval	*Name the following objects that I point to:* Bed ..... Glass/cup ..... Elbow ..... Light ..... Pillow ..... Correct: /5
Auditory verbal communication *(yes/no questions)*	*I'm going to ask you some questions, answer yes or no.* 1. Is your name Smith? 2. Is your name _____? (say patient's last name) 3. Are the lights on in this room? 4. Is the door/curtain closed? 5. Does March come before June? Correct: /5
Speech clarity	☐ Normal ☐ Impaired but easy to understand ☐ Impaired and difficult to understand Comments: .....
Observations: pragmatics	☐ Reduced eye contact ☐ Flat facial expression/voice ☐ Poor conversation turn taking/initiation Other: .....

Sheffield Screening Test for Acquired Language Disorders – Receptive skills

1. Verbal comprehension of single words *I'm going to ask you to point to some of the things in the room...* Door ..... Light ..... Chair ..... Ceiling ..... Corner	/1
2. Comprehension of sequential command a. point to the window and then to the door /1 b. before pointing to the ceiling, touch the chair/bed /1	/2
3. Comprehension of a complex command *Tap the chair/bed twice with a clenched fist, while looking at the ceiling.*	/1

Stop communication assessment HERE and refer to SP if:

☐ Scores 3–5 in language in conversation ☐ Scores <5/5 naming ☐ NESB ☐ Scores <5/5 yes/no questions

☐ Speech clarity "impaired and difficult to understand" ☐ Unable to follow 1 stage command

4. Recognition of differences in meaning between words *I'm going to read you a list of words and I want you to tell me which is the odd one out...* a. chicken, duck, apple, turkey Response: ..... /1 b. run, drink, walk, sprint Response: ..... /1 c. small, large, massive, huge Response: ..... /1	/3
5. Comprehension of Narrative a. *I'm going to read you a short paragraph and then ask you a question about it.* *"John went to the shop to buy a pen. When he got there he found that he had forgotten his wallet, so he came home and made himself a cup of tea. What should he have taken with him?"* Response: ..... /1 b. *I'm going to read you another paragraph.* *"Mrs Smith visited several shops. She bought a newspaper, a cauliflower, a stamp and some sausages. What was the second shop she visited?"* Response: ..... /1	/2
Total receptive skills score	**/9**

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Communication *(continued)*

Sheffield Screening Test for Acquired Language Disorders – Expressive skills

6. Word Finding
Tell me the names of three well-known places (in the client's home town). Response: .... /1

7. Abstract word finding
Tell me another word that means the same as:
a. beautiful Response: ..... /1
b. angry Response: ..... /1
c. ridiculous Response: ..... /1 /3

8. Sequencing
Describe how you would make a cup of tea. Response: ..... /1
A correct answer contains two or more appropriate stages in the right order. /1

9. Definitions
Describe what the following words mean:
a. home Response: ..... /1
b. search Response: ..... /1
c. ambitious Response: ..... /1 /3

10. Verbal reasoning
I'd like you to tell me:
a. why you would use an umbrella Response: ..... /1
b. why people go on holiday Response: ..... /1
c. what would you do if you were locked out of the house Response: ..... /1 /3

Total expressive skills score **/11**

☐ Below normal ☐ ≥ Normal (age 59 and under ≥17; age 60–69 ≥16; age 70 and over ≥15) **TOTAL SCORE** **/20**

Overall impression, communication is:
☐ Functional and no changes identified
☐ Functional but deficits observed or reported, SP review indicated
☐ Not functional or restricted communication, URGENT SP review indicated

☐ **Refer to SP for communication** (reports changes; observed deficits in informal communication screen; stop and refer prompt ticked; below norm or unable to complete Sheffield)

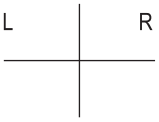
Swallowing

Dysphagia screen completed by: ☐ Nursing ☐ SP ☐ Neither Outcome: ☐ Pass ☐ Fail
Current diet/fluids: .....
Have you noticed any difficulties with your swallowing? ☐ Yes ☐ No If YES, details: .....
Drooling or pooling secretions observed? ☐ Yes ☐ No If YES, details: .....

☐ **Refer to SP for swallowing**

Vision and Perception

Glasses:	☐ Yes	☐ No	Visual tracking:	☐ Intact	☐ Impaired	
Blurry vision:	☐ Yes	☐ No	Convergence:	☐ Intact	☐ Impaired	
Diplopia:	☐ Yes	☐ No	Visual field:	☐ Intact	☐ Impaired *(indicate →)*	
Nystagmus:	☐ Yes	☐ No	Visuospatial neglect:	☐ Left	☐ Right	☐ No
Reading:	☐ Intact	☐ Impaired				



Comments: .....

☐ **Refer to OT for:** .....

Respiratory Assessment

Medical history: ☐ Asthma ☐ COPD ☐ Bronchiectasis ☐ Active lung cancer ☐ Other *(specify)*: .....
Shortness of breath: ☐ Yes ☐ No Difficulty breathing: ☐ Yes ☐ No
Phlegm/mucus: ☐ Yes ☐ No Cough on command: ☐ Strong ☐ Weak
RR 9–20 bpm: ..... SpO_2 >95% (>85% for COPD): .....

Safe to proceed to mobility assessment? ☐ Yes ☐ No
If NO, reason: ☐ Shortness of breath ☐ Difficulty breathing ☐ SpO2 ≤95% (≤85% for COPD)

☐ **Refer to PT for review** (medical history; "yes" to any question; weak cough; RR or SpO_2 outside range)

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Upper and Lower Limbs

Dominance: ☐ Left ☐ Right Affected limb(s): .....

Hypertonicity: ☐ Left ☐ Right ☐ No .....

Oedema: ☐ Yes ☐ No ..... Pain (VAS): .....

Limb	ROM/MMT		Light touch sensation		Proprioception	
	Left	Right	Left	Right	Left	Right
Upper limb						
Lower limb						

Coordination

FNF: ☐ Intact ☐ Impaired – details: .....

Diadochokinesis: ☐ Intact ☐ Impaired – details: .....

Heel-shin slide*: ☐ Intact ☐ Impaired – details: *Do not complete if poor skin integrity* .....

Foot-tapping: ☐ Intact ☐ Impaired – details: .....

Sensorimotor neglect: ☐ No ☐ Left ☐ Right

Shoulder precautions required? ☐ Yes ☐ No

If YES: ☐ Left ☐ Right ☐ "Support my arm" band provided ☐ Collar and Cuff provided ☐ Positioning charts provided

Comments: .....

.....

.....

.....

Safe to proceed to mobility assessment? ☐ Yes ☐ No If NO, reason: ☐ Cognition ☐ Neglect ☐ LL < 3/5 ☐ LL ataxia

Refer to ☐ **OT** ☐ **PT for:** .....

Functional Mobility Assessment

Vestibular screen Vestibular Screening Tool (VST): ..... /8 *Stop and refer to PT if VST ≥4/8 (do not complete mobility assessment)*

Vital signs SBP (mmHg): ..... HR (BMP): ..... Temparture (°C): .....

Check observation chart for usual SBP if: ☐ SBP <110mmHg ☐ SBP >160mmHg

Medical clearance if: ☐ SBP <90mmHg ☐ SBP >180mmHg ☐ HR <40bmp ☐ HR >120bpm

Stop and refer to PT if: ☐ SBP drops ≥20mmHg with change of position ☐ Fevers/>38.5°C

Current LOF

Bed mobility: ☐ Independent ☐ SBA ☐ Assist *Stop and refer to PT if "assist"* .....

Sitting balance: ☐ Independent ☐ SBA ☐ Assist *Stop and refer to PT if "SBA"/"assist"* .....

Transfers: ☐ Independent ☐ SBA ☐ Assist *Stop and refer to PT if "assist"/new aid* .....

Standing balance: ☐ Independent ☐ SBA ☐ Assist *Stop and refer to PT if "assist"/new aid* .....

Mobility: ☐ Independent ☐ SBA ☐ Assist *Stop and refer to PT if "assist"/new aid* .....

10 meter walk test (10MWT) Steps: ..... Time: ..... : ..... Step length: ..... Velocity: .....

Timed up and go (TUG) Time: ..... : ..... Mobility aid: .....

☐ **Refer to PT** **Below normal:** ☐ **10MWT** ☐ **TUG**

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Mood

I'm going to show you some words and pictures, can you pick the one(s) that describes or looks like how you are feeling?

☐ Angry ☐ Scared ☐ Worried ☐ Overwhelmed ☐ Sad ☐ Alone ☐ Vulnerable

☐ Neutral ☐ Calm ☐ Safe ☐ Positive ☐ Happy ☐ Hopeful

Do you have any stressors or worries while you stay in hospital? ☐ Yes ☐ No

If YES, details: .....

Affect observations: ☐ Elated ☐ Teary ☐ Flat/low mood ☐ Anxious ☐ Restless/agitated/fidgety ☐ Avoids eye contact ☐ Dismissive/passive

☐ Other *(specify)*: .....

☐ **Refer to SW** (e.g. anxiety/depression, psychosocial stressors, clinician concerns, incongruent self-report vs. affect observations)

Other observations (e.g. fatigue, patient concerns)

Summary of Assessment and Plan

Allied Health clinical impressions:

Referrals

☐ **OT:** Cognitive assessment (if confirmed TIA/stroke) .....

☐ **PT:** .....

☐ **SP:** .....

☐ **SW:** .....

☐ **Other:** .....

Rehabilitation candidate: ☐ Yes ☐ No ☐ Further assessment required

Safe to discharge: ☐ Yes ☐ No

Name:	Designation:	Signature:	Date:	Time (24hr):

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