Standardized Test Compendium

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2 Minute Walk Test

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2 Minute Walk Test

Purpose

- The 2MWT is a measurement of endurance that assesses walking distance over two minutes.

Equipment

- Stopwatch

General Information

- Ensure the hallway is free of obstacles
- Individual walks without assistance for 2 minutes and the distance is measured
  - start timing when the individual is instructed to "Go"
  - stop timing at 2 minutes
  - assistive devices can be used but should be kept consistent and documented from test to test
  - if physical assistance is required to walk, this should not be performed
  - a measuring wheel is helpful to determine distance walked
- Should be performed at the fastest speed possible

Instructions

- To Patient:
  - Cover as much ground as possible over 2 minutes. Walk continuously if possible, but do not be concerned if you need to slow down or stop to rest. The goal is to feel at the end of the test that more ground could not have been covered in the 2 minutes.

References

Butland RJ. Pang J, Gross ER, Woodcock AA. Geddes DM. Two-, Six,- and 12-minute walking Tests in respiratory disease. Br Med J (Clin Res Ed). 1982 May 29;284(6329): 1607-8

McGavin CR, Gupta SP, McHardy GJ. Twelce-minute walking test for assessing disability in chronic bronchitis. Br Med J. 1976;3;1 (6013): 822-3

2 Minute Walk Test (continued)

Name:_____

Assistive Device and/or Bracing Used:_____

Date:_____

Distance ambulated in 2 minutes:_____

Date:_____

Distance ambulated in 2 minutes:_____

Date:_____

Distance ambulated in 2 minutes:_____

Date:_____

Distance ambulated in 2 minutes:_____

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4 Step Square Test

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4 Step Square Test

Purpose

- Test of dynamic balance that clinically assesses the person's ability to step over objects forward, sideways, and backwards.

Diagnosis/Conditions

- Vestibular Disorders

Equipment

- Stop Watch
- 4 Canes

General Information

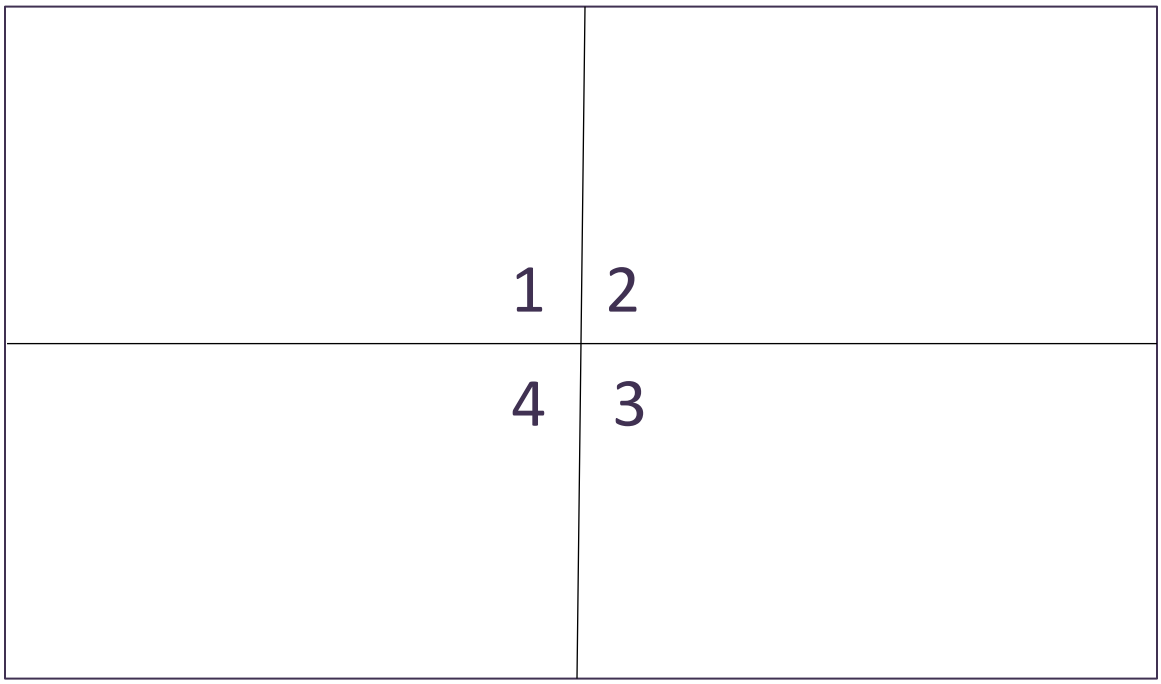
- Time to administer is 5 minutes.
- The patient is instructed to stand in square 1 facing square number 2 (See diagram)
- The patient is required to step as fast as possible into each square in the following sequence: 2, 3, 4, 1, 4, 3, 2, 1
    - Requires the patient to step forward, backward, and sideways to the right and left

Instructions

- Test procedure may be demonstrated and one practice trial is allowed prior to administering the test.
- Two trials are then performed, and the better time (in seconds) is taken as the score.
- Timing starts when the right foot contacts the floor in square.
  "Try to complete the sequence as fast as possible without touching the sticks. Both feet must make contact with the floor in each square. If possible, face forward during the entire sequence."
- Repeat a trial if the patient:
  1) Fails to complete the sequence successfully
  2) Loses balance
  3) Makes contact with the cane
- Patient steps over four canes set-up like a cross on the floor with the tips of the canes facing together.
- At the start of the test, the patient stands on the upper left square (in Square 1, facing Square 2).
- The stepping sequence is (clockwise):
  Square 1, Square 2, Square 3, Square 4, return to Square 1 with both feet.

4 Step Square Test (continued)

- Then (counterclockwise): Back to Square 4, Square 3, Square 2, and end in Square 1 with both feet.
- Patients who are unable to face forward during the entire sequence and may turn before stepping into the next square and are timed accordingly.
- To the Patient:
    - "Try to complete the sequence as fast as possible without touching the sticks. Both feet must make contact with the floor in each square. If possible, face forward during the entire sequence."
- Demonstrate the sequence to the patient
- Ask the patient to complete one practice trial to ensure the patient knows the sequence
- Repeat the trial if the patient is unsuccessful



References:

Dite, W. and Temple, V.A. (2002). "A clinical test of stepping and change of direction to identify multiple falling older adults." Arch Physical Medical Rehabilitation 83 (11): 1566-1571

4 Step Square Test (continued)

Name: _____

Assistive Device and/or Bracing Used: _____

Date: _____

Trial 1 _____ Trial 2 _____

FSST Score (best timed trial): _____

Date: _____

Trial 1 _____ Trial 2 _____

FSST Score (best timed trial): _____

Date: _____

Trial 1 _____ Trial 2 _____

FSST Score (best timed trial): _____

Date: _____

Trial 1 _____ Trial 2 _____

FSST Score (best timed trial): _____

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6 Minute Walk Test

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6 Minute Walk Test

Purpose

- The 6MWT assesses distance walked over 6 minutes as a sub-maximal test of aerobic capacity/endurance.

Equipment

- 6MWT recording form
- Rate of perceived exertion - Borg scale
- Pulse oximeter with appropriate sensor
- Stop watch
- Chairs (number will depend on patient's condition and risk)
- Sphygmomanometer and stethoscope, or similar method of accurately assessing BP
- Trundle wheel for measuring the 6MWT track and the distance walked
- Portable oxygen if required

General Information

- Ideally the test should be conducted on a straight 30-meter track. If the track needs to be adapted or shortened due to lack of space, ensure that the patient walks the same course on each re-test.

Instructions

- 1. Prior to walking say to patient:
  - The object of this test is to walk as FAR AS POSSIBLE for 6 minutes. You will walk back and forth along this course (demonstrate one lap) for six minutes. You may slow down if necessary. If you stop, I want you to continue to walk again as soon as possible. You will be informed of the time and encouraged each minute. Please do not talk during the test unless you have a problem or I ask you a question. You must let know if you have any chest pain or dizziness. When six minutes is up I will ask you to STOP where you are. Do you have any questions?
- 2. To begin say to patient:
  - Start now, or whenever you are ready (start stopwatch when walking starts).
- 3. During the test:
  - Provide the following standard encouragements in even tones. Do not use other words of encouragement or body language to speed up.
  - At 1 minute: "You are doing well. You have 5 minutes to go."
  - At 2nd minute: "Keep up the good work. You have 4 minutes to go."
  - At 3rd minute: "You are doing well. You are halfway done."
  - At 4th minute: "Keep up the good work. You have 2 minutes to go."

6 Minute Walk Test (continued)

- At 5th minute: “You are doing well. You have only 1 minute to go.”
- At 6th minute: “Please stop where you are.”
- If the patient stops during the test:
  - Allow the patient to rest or sit in a chair if they wish, and check SpO2 and heart rate. Ask the patient why they stopped. Keep the stopwatch running and advise: Please resume walking whenever you feel able.

- 4. At the end of the test:
  - Record the total distance walked.
  - Record, heart rate, blood pressure and Rating of Perceived Exertion (RPE). Record recovery time to gain additional information.
  - The patient should remain in a clinical area for at least 15 minutes following an uncomplicated test.

References

https://www.sralab.org/rehabilitation-measures/6-minute-walk-test
www.heartonline.org.au/resources

Standardized Test Compendium

9 Hole Peg Test

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9 Hole Peg Test

General Information

The Nine Hole Peg Test should be conducted with the dominant arm first. One practice trial (per arm) should be provided prior to timing the test. Timing should be performed with a stopwatch and recorded in seconds. The stop watch is started when the patient touches the first peg. The stop watch is stopped when the patient places the last peg in the container.

Set-up

A square board with 9 holes,

- holes are spaced 3.2 cm (1.25 inches) apart
- each hole is 1.3 cm (.5 inches) deep
- 9 wooden pegs should be .64 cm (.25 inches) in diameter and 3.2 cm (1.25 inches) long
- A container that is constructed from .7 cm (.25 inches) of plywood, sides are attached (13 cm x 13 cm) using nails and glue
- The peg board should have a mechanism to decrease slippage. Self-adhesive bathtub appliques were used in the study.
- The pegboard should be placed in front of the patient, with the container holding the pegs on the side of the dominant hand.

Patient Instructions

- The instructions should be provided while the activity is demonstrated. The patient's dominant arm is tested first.

Instruct the patient to:

- "Pick up the pegs one at a time, using your right (or left) hand only and put them into the holes in any order until the holes are all filled. Then remove the pegs one at a time and return them to the container. Stabilize the peg board with your left (or right) hand. This is a practice test. See how fast you can put all the pegs in and take them out again. Are you ready? Go!"

After the patient performs the practice trial, instruct the patient:

- "This will be the actual test. The instructions are the same. Work as quickly as you can. Are you ready? Go!" (Start the stop watch when the patient touches the first peg.)
- While the patient is performing the test say "Faster"
- When the patient places the last peg on the board, instruct the patient "Out again...faster.

9 Hole Peg Test (continued)

- Stop the stop watch when the last peg hits the container.
- Place the container on the opposite side of the pegboard and repeat the instructions with the non-dominant hand.

References

Mathiowetz V, Weber K, Kashman N, Volland G. Adult Norms for the Nine Hole Peg Test of Finger Dexterity. The Occupational Therapy Journal of Research. 1985;5:24-33.

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30 Second Chair Stand Test

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30 Second Chair Stand Test

Purpose

- To assess functional lower extremity strength and endurance in older adults.

Diagnosis/Conditions

- Arthritis and Joint Conditions.

Equipment

- Stop watch
- Chair without arms with seat height of 17 inches
- Wall space

General Information

- The 30-Second Chair Test is administered using a chair without arms with seat height of 17 inches.
- The chair is placed against the wall to prevent it from moving.
- The patient is seated in the middle of the chair, back straight: feet approximately shoulder width apart and placed on the floor at an angle slightly back from the knees, with one foot slightly in front of the other to help maintain balance. Arms crossed at the wrist and held against the chest.
- The patient is encouraged to complete as many full stands as possible within 30 seconds. The patient is instructed to fully sit between each stand.

Instructions

- Take resting vital signs.
- Chair height: 17” (43 cm), placed against wall for stability
- Starting position: sitting in the middle of the chair, back straight, arms crossed over chest, feet flat on the floor.
- Demonstrate the movement, first slowly, then quickly.
- Have the patient/client practice one or two repetitions to ensure proper form, and adequate balance
- On the signal “go” the patient/client rises to a full stand, then returns to a fully seated position, as many times as possible in 30 seconds.
- If a person is more than half way up at the end of the 30 seconds, count it as a full stand.
- One trial.
- Take post exercise vital signs.
- Document any modifications (chair height, assistance needed)

30 Second Chair Stand Test (continued)

Range of scores is between the 25% and 75% percentiles		
Age	Men Number of Stands	Women Number of Stands
60 - 64	14 - 19	12 - 17
65 - 79	12 - 18	11 - 16
70 - 74	12 - 17	10 -15
75 - 79	11 - 17	10 - 15
80 - 84	10 - 15	9 - 14
85 - 89	8 - 14	8 - 13
90 - 95	7 - 12	4 - 11

Scores less than 8 (unassisted) stands were associated with lower levels of functional ability

References:

Rikli RE, Jones CJ (1999). Functional fitness normative scores for community residing older adults ages 60-94. Journal of Aging and Physical Activity, 7, 160-179.

Standardized Test Compendium

Activities-Specific Balance Confidence Scale

(ABC Scale)

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ABC Scale

Purpose

- The purpose of the ABC Scale is to measure an individual's confidence in his/her ability to perform daily activities without falling.

Equipment

- Questionnaire's and pencil

General Information

- This test is best used along with a functional balance test, such as the Berg. This will tell the clinician if their client is over confident or under confident about falling.

Instructions

- Have client fill out form or read questions to them.

References

Powell LE & Myers AM. The Activites-specific Balance Confidence (ABC) Scale. J Gerontol Med Sci 1995; 50 (1): M28-34

ABC Scale (continued)

Client Name: _____ Date: _____ Therapist: _____

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0%	10	20	30	40	50	60	70	80	90	100%
No Confidence										Completely Confident

"How confident are you that you will not lose your balance or become unsteady when you…..

1. ….walk around the house? _____%
2. ….walk up or down stairs? _____%
3. ….bend over and pick up a slipper from front of a closet floor? _____%
4. ….reach for a small can off a shelf at eye level? _____%
5. ….stand on tip toes and reach for something above your head? _____%
6. ….stand on a chair and reach for something? _____%
7. ….sweep the floor? _____%
8. ….walk outside the house to a car parked in the driveway? _____%
9. ….get into or out of a car? _____%
10. ….walk across a parking lot to the mall? _____%
11. ….walk up or down a ramp? _____%
12. ….walk in a crowded mall where people rapidly walk past you? _____%
13. ….are bumped into by people as you walk through the mall? _____%
14. ….step onto or off of an escalator while you are holding onto a railing? _____-%
15. ….step onto or off of an escalator while holding onto parcels such that you cannot hold on to the railing? _____%
16. ….walk outside on icy sidewalks? _____%

ABC Scale (continued)

Confidence in Mobility (Falls Efficacy Scale- FES)

Name: _____ Date: _____

Ask the subject to rate his/her confidence on a scale of 1-10

1 2 3 4 5 6 7 8 9 10

Extremely Confident — No Confidence at All

"How confident are you that you can……[ ]…… without falling?"

Score	Activity
	Take a bath or shower
	Reach into cabinets or closets
	Prepare meals not requiring carrying heavy or hot objects
	Walk around the house
	Get in and out of bed
	Answer the door or telephone
	Get in and out of a chair
	Get dressed and undressed
	Light housekeeping
	Simple shopping
	Total Score

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Arm Curl Test

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Arm Curl Test

Purpose

- The purpose of the Arm Curl Test is to measure functional upper extremity strength for seniors. Upper body strength is important for activities such as carrying laundry, groceries, and luggage.

Equipment

- 5 lb. Weight for women
- 8 lb. weight for men
- Stopwatch
- Straight-back chair with no arms

General Information

- Women will curl a 5-lb. weight in this test and Men will curl an 8-lb. weight for their test. It is extremely important to the accuracy of the test that you use the appropriate weight for men and women in this test.

Instructions

- Patient sitting in the middle of chair with back straight and feet on floor. The weight is held in their dominant hand (use other side if dominant hand is impaired and unable to maintain grasp).
- The arm is positioned with the elbow in extension by the side of the patient's torso, perpendicular with the floor. The wrist is initially positioned in neutral.
- The patient is instructed to turn palm upwards (supinate forearm) while curling the arm through the full range of motion and then return to extension.
- Tell patient when to begin and time them for 30 seconds, using the stopwatch or a watch with a second hand.
- The patient must do as many curls possible in the allotted 30-second time period, moving in a controlled manner.
- Remember they must do a Full Curl, squeezing their lower arm against their upper arm at the top of each curl and returning to a straight arm each time. Make sure they keep their upper arm still. Do Not swing the weight.
- If they have started raising the weight again and are over halfway up when time is called, you may count that curl.
- Record the score on the scorecard.

Standardized Test Compendium

Arm Curl Test (continued)

Arm Curl Test Scoring Sheet

Date:_____

Patient:_____

• Arm used: __ Left __ Right

• Weight:
5lbs (Female): __
8lbs (Male): __

• Number of repetitions completed in 30 seconds_____

Men Age	Below Average	Average	Above Average
60-64	<16	16-22	> 22
65-69	<15	15-21	>21
70-74	<14	14-21	>21
75-79	<13	13-19	>19
80-84	<13	13-19	>19
85-89	<11	11-17	>17
90-94	<10	10-14	>14

Women Age	Below Average	Average	Above Average
60-64	<13	13-19	>19
65-69	<12	12-18	>18
70-74	<12	12-17	>17
75-79	<11	11-17	>17
80-84	<10	10-16	>16
85-89	<10	10-15	>15
90-94	<8	8-13	>13

Arm Curl Test (continued)

References

Anna Różańska-Kirschke, Piotr Kocur, Małgorzata Wilk, Piotr Dylewicz, The Fullerton Fitness Test as an index of fitness in the elderly, Medical Rehabilitation 2006; 10(2): 9-16.

Jones C.J., Rikli R.E., Measuring functional fitness of older adults, The Journal on Active Aging, March April 2002, pp. 24–30.

Balance Assessment Handbook, A Component of the Falls Tool Kit by Stephanie Hart-Hughes, PT NCS VISN 8, Patient Safety Center of Inquiry. James A. Haley Tampa Veterans Hospital. Tampa, FL.

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Barthel Index

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Barthel Index

Patient Name: _____ Date:_____
Instructor Name: _____ Date:_____

Purpose:

- The Barthel Index assesses the ability of an individual with a neuromuscular or musculoskeletal disorder to care for him/herself.

Guidelines

1. The index should be used as a record of what a patient does, not as a record of what a patient could do.
2. The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
3. The need for supervision renders the patient not independent.
4. A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives and nurses are the usual sources, but direct observation and common sense are also important. However direct testing is not needed.
5. Usually the patient's performance over the preceding 24-48 hours is important, but occasionally longer periods will be relevant.
6. Middle categories imply that the patient supplies over 50 per cent of the effort.
7. Use of aids to be independent is allowed.
8. Time to administer is 20 minutes for observation 2-5 minutes for self-report.
9. 10 performance activities assessed
    a. Feeding
    b. Bathing
    c. Grooming
    d. Dressing
    e. Bowels
    f. Bladder
    g. Toilet Use
    h. Transfers (Bed to Chair and Back)
    i. Mobility (On level surfaces)
    j. Stairs

Barthel Index (continued)

Activity

Feeding
0 =unable
5 =needs help cutting, spreading butter, etc., or requires modified diet
10 = independent

Bathing
0 = dependent
5 =independent (or in shower)

Grooming
0 =needs to help with personal care
5 = independent face/hair/teeth/shaving (implements provided)

Dressing
0 = dependent
5 = needs help but can do about half unaided
10 =independent (including buttons, zips, laces, etc.)

Bowels
0 = incontinent (or needs to be given enemas)
5 = occasional accident
10 = continent

Bladder
0 = incontinent, or catheterized and unable to manage alone
5 =occasional accident
10 = continent

Toilet Use
0 = dependent
5 =needs some help, but can do something alone
10 =independent (on and off, dressing, wiping)

Barthel Index (continued)

Transfers (Bed to Chair and Back)

0 =unable, no sitting balance
5 =major help (one or two people, physical), can sit
10 = minor help (verbal or physical)
15 = independent

Mobility (On Level Surfaces)

0 = immobile or < 50 yards
5 = wheelchair independent, including comers, > 50 yards
10 = walks with help of one person (verbal or physical) > 50 yards
15 = independent (but may use any aid; for example, stick) > 50 yards

Stairs

0 =unable
5 = needs help (verbal, physical, carrying aid)
10 = independent

Total (0-100): _____

Scoring Interpretation:

When you collaborate with your patient to determine goals, you should be able to set your target MDI score. Use the MDI crosswalk to translate the anticipated level or assistance at discharge with a score for each item. Add the scores to determine your target MBI.

MBI Discharge Indices

Self-Care Skills	Discharge Options	Support Needed	Hours Needed per week
0-39	24-hour care at home, assisted living or skilled nursing facility	Live-in help who can provide physical assistance	23.4-27
40-59	Managing in a supportive environment	Needing assistance with activities of daily living by a number or community resources	20-23.5
60-84	Back in the community or home	Needing assistance from a number of community resources	13-20
85-99	Back in action	Living independently in your home or the community	<8-13

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Mahoney H, Barthel D. "Functional evaluation: the Barthel Index. “Maryland State Medical Journal1965; 14:56-61. Used with permission.

Loewen SC, Anderson BA. "Predictors of stroke outcome using objective measurement scales." Stroke. 1990;21;78-81,

Gresham GE, Phillips TF, Labi ML. "ADL statt1s in stroke: relative merits of three standard indexes. “Arch Phys Med Rebabil.1980;61:355-358.

Collin C, Wade DT, Davies S, Horne V. "The Barthel ADL Index: a reliability study."111 Disability Stud_d988; 10:61-63.

Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal1965; 14:56-61

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Brief Cognitive Assessment Tool (BCAT)

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Brief Cognitive Assessment Tool (BCAT)

Patient Name _____D.O.B. _____Date _____Sex _____

Purpose

The BCAT is a screening measure for cognitive dysfunction that emphasizes contextual memory and executive control functions.
Cut score: 37/38- dementia <38; non-dementia >39

Instructions

Part 1

Orientation

One point for every correct answer.

- "Tell me the year, month and day of the week."
- "In what state and city are we?"
- "In what situation or setting are we right now?"

☐ Year ☐ Month ☐ Day/week ☐ State ☐ City ☐ Situation

Score: _____

Part 2

Immediate Verbal Recall

Score only 1st trial One point for every correctly recalled word. Give no cues or prompts.

- I am going to read a list of words. When I finish, repeat them after me. I will ask you to recall the words later as well. I am not concerned with the order in which you say them."

	Banana	Justice	Sara	Bridge
1st Trial	☐	☐	☐	☐
2nd Trial	☐	☐	☐	☐

Score: _____

Part 3

Visual Recognition/naming

One point for every correct picture.

- "Can you see these three pictures?" If they say no enlarge the pictures.
- "Tell me the names of this object." Point to the pictures from left to righ.
- "Look at the pictures again, try to memorize them because I will ask you to recall them later."

Brief Cognitive Assessment Tool (BCAT) (continued)

☐ ☐ ☐

Score: _____

Part 4
Attention

No errors=1, error=0

- Read letters, instructing patient to tap with hand at each letter C.
- C F B T O L C C Q A Z C B R B Q W D C S B L R B C B Z X C B

Score: _____

Mental Control

- Instruct participant to count backwards from 20-1

Score: _____

- Instruct participant to recite days of the week backwards from Sunday

Score: _____

Digits

One point for each correctly provided sequence. A total of two points for forward and two point for backwards

- "I am going to say some number. When I am finished, repeat them in the same order as I say them. Listen carefully." Numbers should be read at about one number per second.
- Forward: 25974 517896

Score: _____

- "Now I am going to say some more number. This time, repeat them in backwards order. For example, if I say one, five what would you say?" If the patient says 'five, one' congratulate them if not give them the correct answer
- Backward 627 4189

Score: _____

Brief Cognitive Assessment Tool (BCAT) (continued)

Part 5
Abstraction

Find the similarities- Acceptable answers are abstract or specific. Incorrect answers are too broad.
Apple-Orange- Correct answer "fruit"- Incorrect "something you eat"
Train-Boat- Correct answer "you can ride them"- Incorrect "toys"
Book-Newspaper- Correct answer "things you read"- Incorrect "you put them on tables"

☐ Apple-Orange	☐ Train-Boat	☐ Book-Newspaper

Score: _____

Part 6
Language
Repeat

(no errors=1, error=0)

"I am going to read you a sentence. When I am finished, repeat it exactly as I said it. Ready? Michael married Marie's mother."

Score: _____

Fluency

(>14= 2 points, 8-14= 1 point, <8= 0 points)

"I am going to ask you to tell me as many names as you can think of. I will tell you when to begin and when to stop. You will have one minute to complete this task. Okay, tell me as many girl names as you can think of. Begin, now… (after one minute) stop."

Score: _____

Part 7
Executive
Cognitive Shifting

(>7=2 points, 6-7=1 point <6=0 points)

- Administrator says; "I am going to ask you to do some counting. Please count from 1 to 10. Are you ready? Begin. Okay, now I want you to say your alphabet. Start with the letter A and continue until you say the letter J. Begin." Note: This part is not recorded. If the patient cannot count to five and cannot say the alphabet through E, do not proceed to part B, and give the score of zero.
- Administrator says; "Now I would like you to say numbers and letters. I will ask you to switch between numbers and letters, but keeping them in proper order. You would say 1-A-2-B-3-C, and so forth. Okay start with 1-A and keep going until I ask you to stop. Begin."

Brief Cognitive Assessment Tool (BCAT) (continued)

1A – 2B – 3C – 5D – 6E – 7F – 8G – 9I – 10J Score: _____

Arithmetic Reasoning

1 point for the correct answer. You can repeat the question one time but no cueing.

- "Now I am going to ask you to work through a practical problem. Here it is: You have $25 to spend at the grocery store. You buy milk for $3, 2 apples for $1. How much money do you have left?" Score: _____

Judgment

1 point for the correct answer. You can repeat the question one time but no cueing.

- "Suppose you have a 1pm appointment with your doctor. It takes 45 minutes to get there. What is the latest you can leave to get there by 1pm?" Score: _____

Part 8

Visuospatial

Design

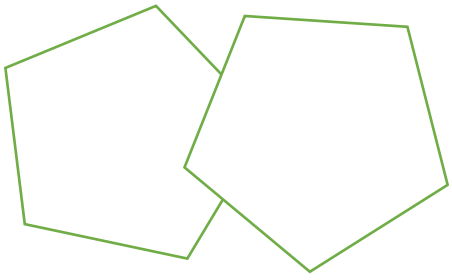
- "Copy this design as accurately as you can." Give one point if the patient makes two 5-sided figures. Give a second point if the figures intersect such that the 'common' space is smaller than the other design spaces.

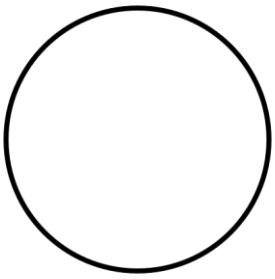
Clock

- In the circle provided, draw a clock. First put in the numbers, and then set the time to 10 after 11." Give one point if the numbers are placed in a reasonable accurate order and if they are legible. Give a second point if the clock hands generally indicate '10 after 11.'

Design/clock (Design) Score: _____

(Clock) Score: _____





Brief Cognitive Assessment Tool (BCAT) (continued)

Part 9
Delayed Verbal Recall

One point for each correctly recalled word.

- "I read some words to you a brief time ago. Tell me as many of the words as you can recall."

	Banana	Justice	Sara	Bridge
No Cue	☐	☐	☐	☐
With Cue	☐	☐	☐	☐

Score: _____

Part 10
Immediate Story Recall

Instructions: >7= 2 points, 4-7= 1 point, <4= 0 points

- "I'm going to read you a short story. When I am finished, tell me as much of the story, in all detail that you can remember. Later, I will ask you to recall the story details again." Every recalled detail gets one point.
- Carol/borrowed/$10/ from her brother/ Jack/ last week. / She couldn't pay him back/ because she bought/ a delicious/ ice cream cone/ at the circus instead.

Score: _____

Part 11
Delayed Visual Memory

One point for every correctly recalled object.

- "I showed you some pictures of objects a short time ago. Tell me as many of the names of those objects as you can."

☐ _____ ☐ _____ ☐ _____

Score: _____

Part 12
Delayed Story Recall

Instructions: >7= 2 points, 4-7= 1 point, <4= 0 points

- "A short time ago I read you a story about a brother and a sister. Tell me everything you remember about this story." Every recalled detail gets one point.
- Carol/borrowed/$10/ from her brother/ Jack/ last week. / She couldn't pay him back/ because she bought/ a delicious/ ice cream cone/ at the circus instead.

Score: _____

Brief Cognitive Assessment Tool (BCAT) (continued)

Part 13
Story Recognition

One point for each correct answer.

- "Now I am going to ask you some questions about the story. After I ready each question, I will then read three possible answers. You tell me the right answer."

What was the name of the woman who borrowed the money?	Carol	Mary	Sue
How much money did she borrow?	$15	$10	$16
What was the name of the woman's brother?	Robert	Tom	Jack
What did the woman buy?	Ice Cream	Sandwich	Soda
Where did the woman go?	Mall	Circus	Grocery

Standardized Test Compendium

Brief Cognitive Assessment Tool (BCAT)

Kitchen Picture Test

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Brief Cognitive Assessment Tool (BCAT)
Kitchen Picture Test

Patient Name _____D.O.B. _____Date _____Sex _____

Purpose

- The BCAT is a screening measure for cognitive dysfunction that emphasizes contextual memory and executive control functions.

Instructions

Part 1

Expressive Language

Scoring: 2= No apparent Deficit, 1= Mild Deficit, 0= Severe Deficit

- Say to participant: "I am going to show you a picture. Please describe what you see."
- Fluency (Spontaneous Verbal Output Quality) _____
- Naming (Ability to Accurately Name Objects) _____
- Repetition (Repeating Words or Perseverating) _____
- Word-Substitution (Substituting with Incorrect Words) _____
- Neologisms (Inventing Words) _____

Part 2

Practical Judgement

- Say to the participant: "There are safety problems in this picture. Please tell me what they are. Now, tell me how you would order them in terms of safety. Tell me the most important problem, then the third." (Ask the patient to explain the rationale for the ordering, if not already evident.)
- "Okay now tell me how you would deal or resolve each situation."
- Does the patient identify the 3 problem situations? _____
- As a whole, is the ordering in magnitude reasonable? _____
- For each problem, is problem-solving appropriate? _____

Part 3

Visual Memory

Scoring: 3=3 Recalled, 2=2 Recalled, 1=1 Recalled, 0=0 Recalled

- Say to participant "A short time ago, I showed you a picture in which there were safety problems. Please tell me what those problems are."
- Accurate recall of the three problem situations. _____

Brief Cognitive Assessment Tool (BCAT)
Kitchen Picture Test (continued)

Results

- Duration of visual delay: _____
- Total BCAT score: _____
- The BCAT is a screening measure for cognitive dysfunction that emphasizes contextual memory and executive control functions.

Standardized Test Compendium

Berg Balance Scale

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Berg Balance Scale

Purpose

The purpose is to measure balance among older people with impairment in balance function by assessing the performance of functional tasks.

Diagnosis/Conditions

Arthritis & Joint Conditions, Brain Injury, Multiple Sclerosis, Parkinson's Disease, Neurologic Conditions, Spinal Cord Injury, Stroke Recovery

Equipment

- Ruler
- Two standard chairs
    - One with arm rests, one without
- Foot stool or step
- Stopwatch
- 15 ft walkway

General Information

- 14-item scale designed to measure balance of the older adult in clinical testing
    - Sitting to Standing
    - Standing Unsupported
    - Sitting Unsupported Feet on Floor
    - Standing to Sitting
    - Transfers
    - Standing Unsupported with Eyes Closed
    - Standing Unsupported with Feet Together
    - Reaching Forward with Outstretched Arm:
    - Pick Up Object from the Floor
    - Turn to Look Behind Over Left and Right Shoulders
    - Turn 360 Degrees
    - Count Number of Times Step Touch Measured Stool:
    - Standing Unsupported One Foot in Front
    - Standing on One Leg
- Recommended for ACL of 4.0 or greater.
- Completion time: 15-20 minutes

Berg Balance Scale (continued)

Instructions

- Document each task and/or give instructions as written. When scoring, please record the lowest response category that applies for each item.
- The subject is asked to maintain a given position for a specific time- Progressively more points are deducted if:
    - The time or distance requirements are not met
    - The subject's performance warrants supervision
    - The subject touches an external support or receives assistance from the examiner
- Subject should understand that they must maintain their balance while attempting the tasks. The choices of which leg to stand on or how far to reach are left to the subject. Poor judgement will adversely influence the performance and the scoring.

Instructions for each category

Sitting to Standing "Please stand up. Try not to use your hands for support."

- 4 points if able to stand without using hands and stabilize independently
- 3 points if able to stand independently using hands
- 2 points if able to stand using hands after several tries
- 1 point needs minimal aid to stand or to stabilize
- 0 points needs moderate or maximal assist to stand

Standing Unsupported "Stand for 2 minutes without holding."

- 4 points if able to stand safety for 2 minutes
- 3 points if able to stand 2 minutes with supervision
- 2 points if able to stand 30 seconds unsupported
- 1 point needs several tries to stand 30 seconds unsupported
- 0 points unable to stand 30 seconds unassisted

Sitting Unsupported Feet on Floor "Sit with arms folded for two minutes"

- 4 points if able to sit safely and securely for 2 minutes
- 3 points if able to sit 2 minutes under supervision
- 2 points if able to sit for 30 seconds
- 1 point if able to sit for 10 seconds
- 0 points unable to sit without support for 10 seconds

Berg Balance Scale (continued)

Standing to Sitting "Please sit down"

- 4 points if able to sit safely with minimal use of hands
- 3 points if able to control descent by using hands
- 2 points if uses back of legs against chair to control descent
- 1 point if sits independently but has uncontrolled descent
- 0 points needs assistance to sit

Transfers "Please move from chair to chair/mat and back again. One way toward a seat with armrests and one way toward a seat without armrests."

- 4 points if able to transfer safely with minor use of hands
- 3 points if able to transfer safely definite need of hands
- 2 points if able to transfer with verbal cueing and/or supervision
- 1 point if needs one person to assist
- 0 points if needs two people to assist and supervise to be safe

Standing Unsupported with Eyes Closed "Close your eyes and stand still for 10 seconds."

- 4 points if able to stand safety for 10 seconds
- 3 points if able to stand 10 seconds with supervision
- 2 points if able to stand 3 seconds
- 1 point if unable to keep eyes closed for 3 seconds but stays steady
- 0 points needs help to keep from falling

Standing Unsupported with Feet Together "Place your feet together and stand without holding."

- 4 points if able to place feet together independently and stand 1 minute safely
- 3 points if able to place feet together independently and stand 1 minute with supervision
- 2 points if able to place feet together independently and hold for 30 seconds
- 1 point needs help to attain position but able to stand 15 seconds feet together
- 0 points needs help to attain position and unable to hold for 15 seconds

Berg Balance Scale (continued)

Reaching Forward with Outstretched Arm "Lift arm to 90 degrees. Stretch out your fingers and reach forward as far as you can."

- 4 points if able to reach forward confidently >25 cm (10 inches)
- 3 points if able to reach forward >12.5 cm safely (5 inches)
- 2 points if able to reach forward >5 cm safely (2 inches)
- 1 point if reaches forward but needs supervision
- 0 points if loses balance while trying/requires external support

Pick Up Object from the Floor "Pick up the shoe which is placed in front of your feet."

- 4 points if able to pick up shoe safely and easily
- 3 points if able to pick up shoe but needs supervision
- 2 points if unable to pick up but reaches 2-5cm (1-2 inches) from slipper and keeps balance independently
- 1 point if unable to pick up and needs supervision while trying
- 0 points if loses balance while trying/requires external support

Turn to Look Behind Over Left and Right Shoulders "Turn to look behind you, over toward left shoulder. Repeat to the right."

- 4 points if looks behind from both sides and weight shifts as well
- 3 points if looks behind one side only other side shows less weight shift
- 2 points if turns sideways only but maintains balance
- 1 point if needs supervision when turning
- 0 points if needs assist to keep from losing balance or falling

Turn 360 Degrees "Turn completely around in a full circle. Pause. Then turn a full circle in the other direction."

- 4 points if able to turn 360 degrees safely in 4 seconds or less
- 3 points if able to turn 360 degrees safely one side only in 4 seconds or less
- 2 points if able to turn 360 degrees safely but slowly
- 1 point if needs close supervision or verbal cueing
- 0 points if needs assistance while turning

Berg Balance Scale (continued)

Count Number of Times Step Touch Measured Stool "Place foot alternatively on the stool (6"-8"). Continue until each foot has touched the stool four times."

- 4 points if able to stand independently and safely and complete 8 steps in 20 seconds
- 3 points if able to stand independently and complete 8 steps in >20 seconds
- 2 points if able to complete 4 steps without aid with supervision
- 1 point if able to complete >2 steps needs minimal assist
- 0 points if needs assistance to keep from falling/unable to try

Standing Unsupported One Foot in Front "Place one foot directly in front of the other. If you feel that you cannot place your foot directly in front, try to step far enough ahead that the heel of your forward foot is ahead of the toes of the other foot."

- 4 points if able to place foot tandem independently and hold 30 seconds
- 3 points if able to place foot ahead of other independently and hold 30 seconds
- 2 points if able to take small step independently and hold 30 seconds
- 1 point if needs help to step but can hold 15 seconds
- 0 points if loses balance while stepping or standing

Standing on One Leg "Stand on one leg as long as you can without holding."

- 4 points if able to lift leg independently and hold >10 seconds
- 3 points if able to lift leg independently and hold 5-10 seconds
- 2 points if able to lift leg independently and hold =or>3 seconds
- 1 point if tries to lift leg unable to hold 3 seconds but remains standing independently
- 0 points if unable to try or needs assist to prevent fall

Berg Balance Scale (continued)

Scoring

- A five-point scale, ranging from 0-4. “0” indicates the lowest level of function and “4” the highest level of function. Total Score=56

Scoring Interpretation

- 0-20 Wheelchair bound
- 21-40 Walking with Assistance
- 41-56 Walking without Assistance
- Scores <36 show almost 100% risk of fall
- Scores <45 accepted as a high risk for a fall

References

https://www.sralab.org/rehabilitation-measures/berg-balance-scale
http://geriatrictoolkit.missouri.edu/

Berg Balance Scale (continued)

Patient Name_____

Site of Service_____ Patient ID_____

Score 0-4

	Description	Date	Date	Date	Date	Date
1.	Sitting to Standing					
2.	Standing Unsupported					
3.	Sitting Unsupported					
4.	Standing to Sitting					
5.	Transfers					
6.	Standing with Eyes Closed					
7.	Standing with Feet Together					
8.	Reaching Forward with Outstretched Arm					
9.	Retrieving Object from Floor					
10.	Turning to Look Behind					
11.	Turning 360 Degrees					
12.	Placing Alternate Foot on Stool					
13.	Standing with One Foot in Front					
14.	Standing on One Leg					
	Total Score	/56	/56	/56	/56	/56

Standardized Test Compendium

BORG Rating Scale

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BORG Rating Scale

Purpose

- The Borg Rating of Perceived Exertion (RPE) is a way of measuring physical activity intensity level. Perceived exertion is how hard you feel like your body is working. It is based on the physical sensations a person experiences during physical activity, including increased heart rate, increased respiration or breathing rate, increased sweating, and muscle fatigue. Although this is a subjective measure, a person's exertion rating may provide a fairly good estimate of the actual heart rate during physical activity.

Instructions

- While doing physical activity, we want you to rate your perception of exertion. This feeling should reflect how heavy and strenuous the exercise feels to you, combining all sensations and feelings of physical stress, effort, and fatigue. Do not concern yourself with any one factor such as leg pain or shortness of breath, but try to focus on your total feeling of exertion.
- Look at the rating scale below while you are engaging in an activity; it ranges from 6 to 20, where 6 means "no exertion at all" and 20 means "maximal exertion." Choose the number from below that best describes your level of exertion. This will give you a good idea of the intensity level of your activity, and you can use this information to speed up or slow down your movements to reach your desired range.
- Try to appraise your feeling of exertion as honestly as possible, without thinking about what the actual physical load is. Your own feeling of effort and exertion is important, not how it compares to other people's. Look at the scales and the expressions and then give a number.

6	No exertion at all
7	Extremely light (7.5)
8	
9	Very Light
10	
11	Light
12	
13	Somewhat hard
14	
15	Hard (heavy)
16	
17	Very Hard
18	
19	Extremely hard
20	Maximal exertion

- 9 corresponds to "very light" exercise. For a healthy person, it is like walking slowly at his or her own pace for some minutes.

BORG Rating Scale (continued)

- 13 on the scale is “somewhat hard” exercise, but it still feels OK to continue.
- 17 “very hard” is very strenuous. A healthy person can still go on, but he or she really must push him or herself. It feels very heavy, and the person is very tired.
- 19 on the scale is an extremely strenuous exercise level. For most people, this is the most strenuous exercise they have ever experienced.

References

http://www.cdc.gov/physicalactivity/everyone/measuring/exertion.html

Standardized Test Compendium

Brunel Balance Assessment (BBA)

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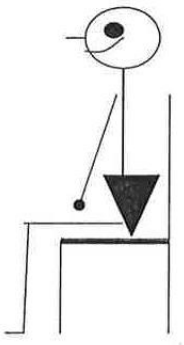
Standardized Test Compendium

Brunel Balance Assessment (BBA)

Level 1 Supported Sitting- Timed Test

Instructions

- The subject is seated on a firm, level surface without back support and their feet flat on the floor. They can use upper limb support if they wish. Stand beside the subject to give support if necessary.
- Explain the test to the subject: "I want to time how long you can sit without me helping you. You can use your arms to support yourself if you wish. When I say go try and keep your balance for as long as you can or until I say stop."
- Use a stopwatch to time how long they can maintain sitting balance for up to 30 seconds. Call out the time every 10 seconds.
- If the subject keeps his/her balance for at least 30 seconds with upper limb support but without assistance from the tester then the subject has passed.
- If the subject kept his/her balance for less than 30 seconds or if he/she needed assistance from tester then the subject has failed.
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

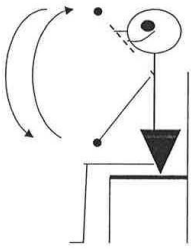


Brunel Balance Assessment (BBA) (continued)

Level 2 Static Sitting Balance- Sitting Arm Raise Test

Instructions

- The subject is seated on a firm. Level surface without back support, feet flat on the floor and hands resting on lap.
- Explain and demonstrate the movement to the subject, get them to practice it and correct as necessary. “I want to see how many times you can lift your sound arm up and down in 15 seconds. When I say go raise and lower your arm as often as you can, until I say stop.”
- Use the stop-watch to time 15 seconds. Count the number of times the subject can raise his/her sound arm (his/her maximum shoulder flexion) and return it back to their sound knee. A lift does not count if the subject does not achieve full flexion.
- Pass= 3 or more arm lifts
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

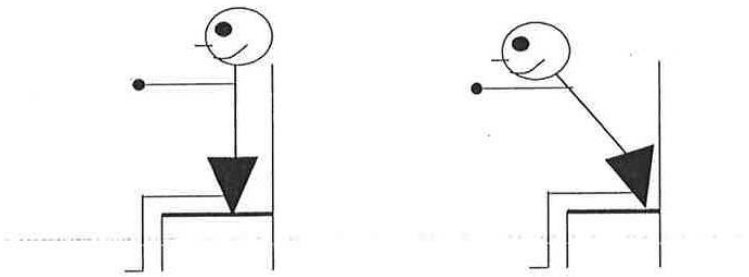


Brunel Balance Assessment (BBA) (continued)

Level 3 Dynamic Sitting Balance- Sitting Forward Reach Test

Instructions

- The subject is seated with hips at 90 degrees on a firm, level surface without back support, feet flat on the floor and hands resting on lap. Stand beside the subject to give support if necessary.
- The height of the ruler is adjusted so that it is at the level of the acromion of the sound shoulder. The subject lifts his/her sound arm to shoulder height with fingers curled into a fist while sitting in a normal, comfortable position. Position the ruler so that the end of the ruler touches the knuckles of the outstretched arm and it continues in a forward direction.
- The subject reaches forwards as far as possible with their hand level with the ruler. When at maximum reach, the tester reads the position of the knuckle of the middle finger for the ruler.
- Explain and demonstrate the movement to the subject, get them to practice it and correct as necessary: "I want you to reach forwards as far as you can, keeping your hand level with the ruler. When you are at full stretch hold the position for a few seconds while I read the ruler then sit back. Keep your feet on the ground, and your bottom on the seat, do not use your weak arm for support."
- Read and note the position of the knuckle of the middle finger on the ruler. Repeat this test. Take the average of the two scores.
- Pass=Average value is 7cm or more, without upper limb support and/or assistance from the tester
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.



Brunel Balance Assessment (BBA) (continued)

Level 4 Supported Standing- Timed Test

Instructions

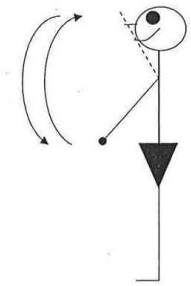
- The subject stands on a firm, level surface in normal shoes with feet in a comfortable, level position, and holding on to furniture if necessary. Provide support at waist height in front or to the sound side e.g. a plinth, bedside cupboard or back of a chair. Stand beside the subject to give assistance as necessary.
- Explain the test to the subject: "I want to time how long you can stand without me helping you. You can hold on if you wish. When I say go try to keep your balance for as long as you can or until I say stop."
- Time how long the subject can maintain standing balance for up to 30 seconds. Call out the time every 10 seconds.
- Pass= The subject keeps his/her balance for 30 seconds or more with or without support and without assistance from the tester
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

Brunel Balance Assessment (BBA) (continued)

Level 5 Static Standing Balance- Standing Arm Raise Test

Instructions

- The subject stands on a firm, level surface with feel level without upper limb support. Stand beside the subject to give support. Explain and demonstrate the movement to the subject, practice and correct as necessary.
- Explain the test to the subject: "I want to count how many times you can lift your sound arm in 15 seconds. When I say go raise and lower your sound arm as often as you can, until I say stop."
- Time 15 seconds count the number of times the subject can raise and lower their sound arm to their side in this time.
- Pass= Subject performs 3 or more arm lifts
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

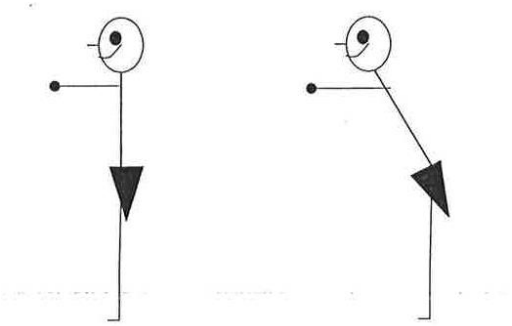


Brunel Balance Assessment (BBA) (continued)

Level 6 Dynamic Standing Balance- Standing Forward Reach Test

Instructions

- The subject stands on a firm, level surface with feel level without upper limb support. Stand beside the subject to give support.
- The height of the ruler is adjusted so that it is at the level of the acromion of the sound shoulder. The subject lefts his/her sound arm to shoulder height with fingers curled into a fist.
- Position the ruler so that the knuckles of the outstretched arm are level with the end of the ruler, and the ruler points forwards in front of the subject.
- The subject reaches forwards as far as possible with their hand level with the ruler. When at maximum reach the tester reads the position of the knuckle of the middle finger from the ruler.
- Explain and demonstrate the movement to the subject, get them to practice and correct as necessary: "I want you to reach forwards as far as you can with you hand level with the ruler. When at full stretch hold the position for a few seconds while, I read the ruler, then return upright. Keep your heels on the ground and do not use your weak arm for support." Note the ruler reading and repeat. Take an average of the two scores.
- Pass= The average of the two scores is 5cm or more, without upper limb support and/or assistance from the tester.
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

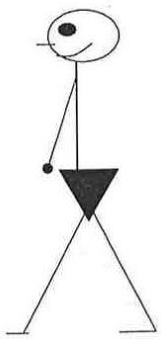


Brunel Balance Assessment (BBA) (continued)

Level 7 Static Double Stance- Timed Step-Standing Test

Instructions

- The subject stands without upper limb support on a firm, level surface in step standing position;(sound foot in front of weak foot, with sound heel level or beyond the toes of the weak foot, both knees extended). Stand beside the subject to give support.
- Explain the test to the subject, demonstrate and practice as necessary: "I want to time how long you can stand without me helping you. Keep your arms by your sides. When I say go try and keep your balance for as long as you can or until I say stop."
- Time how long they can maintain the step standing position for up to 30 seconds. Call out the time every 10 seconds.
- Pass= The subject keeps his/her balance for 30 seconds or more, without support and/or assistance from the tester.
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

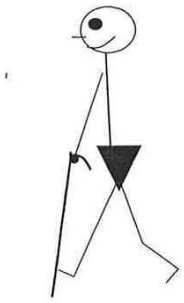


Brunel Balance Assessment (BBA) (continued)

Level 8 Supported Sing Stance- Walking with an Aid

Instructions

- A distance of 5 meters is marked on the floor. The subject starts to walk a couple of strides before the "start line" and does not stop until he/she crosses the "finish line." Stand/walk beside the subject to give support.
- Explain and demonstrate the test as necessary: "I am going to time how fast you walk. Walk at your natural pace between these two markers. Do not slow down until you have crossed the finish line. Start when I say go."
- Time how long it takes to walk the distance and not the time. Repeat test and take an average of the two scores.
- Pass= Average value is 1 minute or less, without physical support from the tester.
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

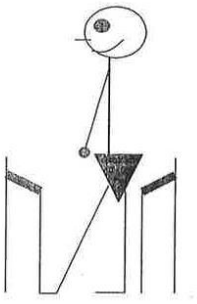
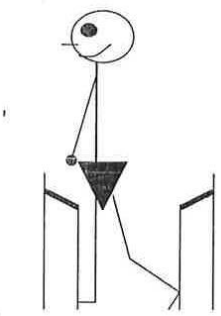
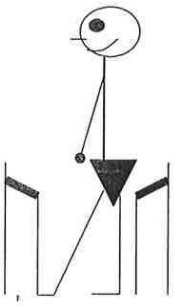


Brunel Balance Assessment (BBA) (continued)

Level 9 Dynamic Double Stance- Weight Shift Test

Instructions

- Starting position: The subject stands without upper limb support on a firm, level surface in step- standing position (weak foot in front, with weak heal level or beyond the sound toes). A perching stool or walking frame adjusted to him/tummy height is positioned so that the horizontal bar is over the 5th metatarsal of the weak food. Another frame or stool is positioned behind the subject at hip/bottom level, so their bottom touches the stool when their weight is on the sound leg. Stand beside the subject to give support as necessary.
- Movement: The subject transfers his/her weight onto the weak leg so that his/her tummy touches the back of the stool, and then back on to the sound leg so that their bottom touches the other stool. The subject needs to stand upright and keep his/her hips neutral/extended. The sound heel may lift as weight is transferred forwards but it must be on the floor when weight bearing.
- Explain and demonstrate the test, practice and correct as necessary: "I want to count how many times you can transfer your weight on to the weak leg so that your tummy touches the other stool/frame. Keep your hips and knees straight when your weight is on the leg, but you can bend your sound knee and raise your heel as you bring your weight forwards. Do this as many times as you can until I say stop."
- Time 15 seconds, and count the number of times the subject touches the bar of the frame at the front.
- Pass= Subject performs 3 or more transfers.
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

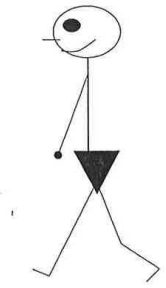
1. 
2. 
3. 

Brunel Balance Assessment (BBA) (continued)

Level 10 Changing the Base of Support Between Double and Single Stance- Walking Without an Aide

Instructions

- A distance of 5 meters is marked on the floor. The subject starts to walk a couple of strides before the "start line" and does not stop until he/she has crossed the "finish line." Stand/walk beside the subject to give support.
- Explain and demonstrate the test as necessary: "I am going to time how fast you walk. Walk at your natural pace between these two markers. Do not slow down until you have crossed the finish line. Start when I say go."
- Time how long it takes to walk this distance, note the time. Repeat the test and take an average of the two scores.
- Pass= Average values is 1 minute or less, without physical support from the tester.
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

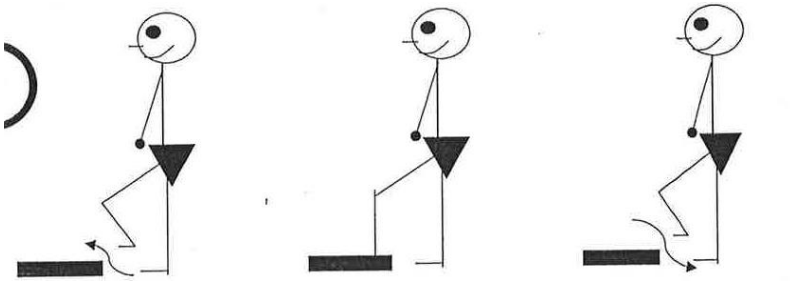


Brunel Balance Assessment (BBA) (continued)

Level 11 Dynamic Single Stance- Tap Test

Instructions

- The subject stands on a firm level surface with feel level. A 7.5-10cm high block is positioned a hands width (10cm) in front of his/her toes. The subject places his/her sound foot on and off the block as often as possible within 15 seconds (but does not step up). The subject should place his/her whole foot on the block. Stand beside the subject to give support.
- Explain and demonstrate the test, practice and correct as necessary: "I want to count how many times you can place your sound foot on and off this block, without stepping up onto the block. When I say go put your sound foot onto the block and then take it off again. Do this as many times ad you an until I say stop."
- Time 15 seconds, and count aloud the number of steps the subject performs.
- Pass= Subject performs 2 or more foot steps
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.

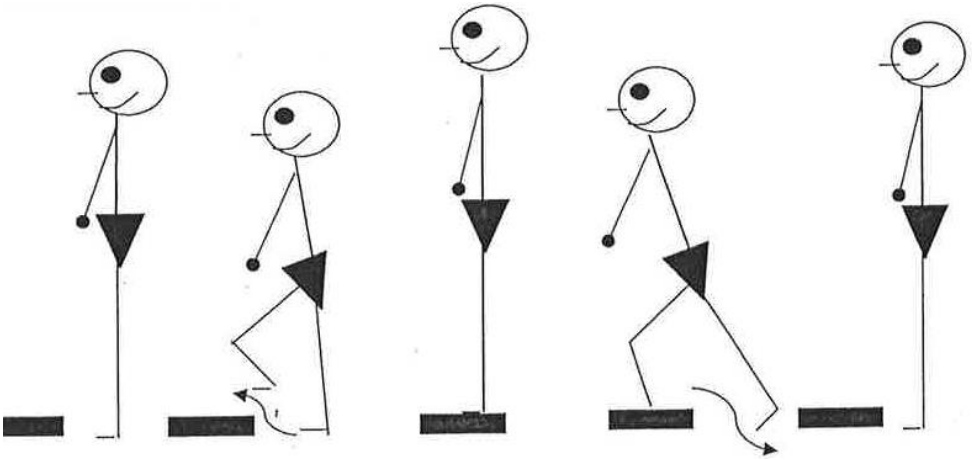


Brunel Balance Assessment (BBA) (continued)

Level 12 Changing the Base of Support- Step-Up Test

Instructions

- The subject stands on a firm level surface with feet level. A 7.5-10cm high block is positioned a hands width (10cm) in front of his/her toes. The subject steps up, onto, and off the block leading with their weak leg as often as possible within 15 seconds. A step-up is completed when weak leg is placed on the floor again. Stand beside the subject to give support.
- Explain and demonstrate the test, practice and correct as necessary: "I want you to step up on to the block and then off again, leading with your weak leg. When I say go do this as often as you can until I say stop."
- Time 15 seconds and count the number of steps-up performed.
- Pass= Subject performs 1 or more step up and down
- If the subject fails, repeat the test once or twice more. If the subject passes by the third attempt, proceed to the next level.



Brunel Balance Assessment (BBA) (continued)

Score Sheet

Test Number	Test Name	Score Attempt Number 1	Score Attempt Number 2	Score Attempt Number 3	Pass (Y/N)	Pass Criteria (after up to 3 attempts)
1	Supported Sitting- Timed Test					Sit supported for 30 seconds
2	Static sitting- sitting arm raise test					3 or more arm lifts in 15 seconds
3	Dynamic sitting- Sitting forward reach test					Reach forward more than 7cm (average of 2 readings)
4	Supported standing- Timed test					Stand supported for 30 seconds
5	Static standing balance- Standing arm raise test					3 or more arm lifts in 15 seconds
6	Dynamic standing- Standing forward reach test					Rach forward more than 5cm (average of 2 readings)
7	Static double stance- Timed step standing test					Static step standing for 30 seconds
8	Supported single stance- walking **with** an aid					Walk 5m within 1 minute (average of 2 readings)
9	Dynamic double stance- Weight shift test					3 or more shifts within 15 seconds
10	Changing base of support- walking **without** an aid					Walk 5m within 1 minute (average of 2 readings)
11	Dynamic single stance- Tap test					2 or more taps within 15 seconds
12	Changing the base of support- step-up test					1 or more step-up(s) within 15 seconds

Brunel Balance Assessment (BBA) (continued)

References

Tyson S & DeSouza L (2002). Measurement of balance and walking post-stroke: Part 1 Ordinal Scales. Physical Therapy Reviews 2002;7;3;177-85

Tyson S & DeSouza L (2002). Measurement of balance and walking post-stroke: Part 2 Functional Performance Tests. Physical Therapy Reviews 2002;7;3;87-91

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Standardized Test Compendium

Chair Step Test

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Chair Step Test

Information

The patient is seated in a standard 18" chair with no arms. A bar is placed in front of the client that is as far away as needed to require almost full knee extension to touch it. The height of the bar is 6 inches. Prior to performing the test, take heart rate a couple of times. Having a metronome is ideal but not necessary. Set metronome to 60 beats/min.

Step 1

- Touch the bar with alternating feet 60x/min for 3 full min.
- Record Heart Rate
- VO_2 =8 ml/kg/min - 2.3 METS

Stage 2

- Move the bar height to 12"
- Repeat touching the bar with alternating feet for 3 minutes
- Record Heart Rate
- $V0_2$ =10 ml/kg/min - 2.9 METS

Stage 3

- Move the bar height to 18"
- Do alternating foot touches, one/second, for three full minutes or fatigue
- Take Heart Rate
- $V0_2$ = 12.3 ml/kg/min.- 3.5 METS

Stage 4

- The bar remains at 18 inches.
- Arm activity is added to the leg activity. So, while patients are reaching with one leg toward the bar, they are simultaneously raising the arm on the same side to shoulder height.
- Take Heart Rate
- $V0_2$ = 13.7 ml/kg/min. - 3.9 METS

Heart Rate (220-age) is used as a proxy for $V0_2$. Alternative, use Borg's scale of perceived exertion. It correlates well with intensity of physical demand.

Standardized Test Compendium

Clock Drawing Test

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Clock Drawing Test

Instructions

- Give patient a sheet of paper with a large (relative to the size of handwritten numbers) predrawn circle on it. Indicate the top of the page.
- Instruct patient to draw numbers in the circle to make the circle look like the face of a clock and then draw the hands of the clock to read "10 after 11".

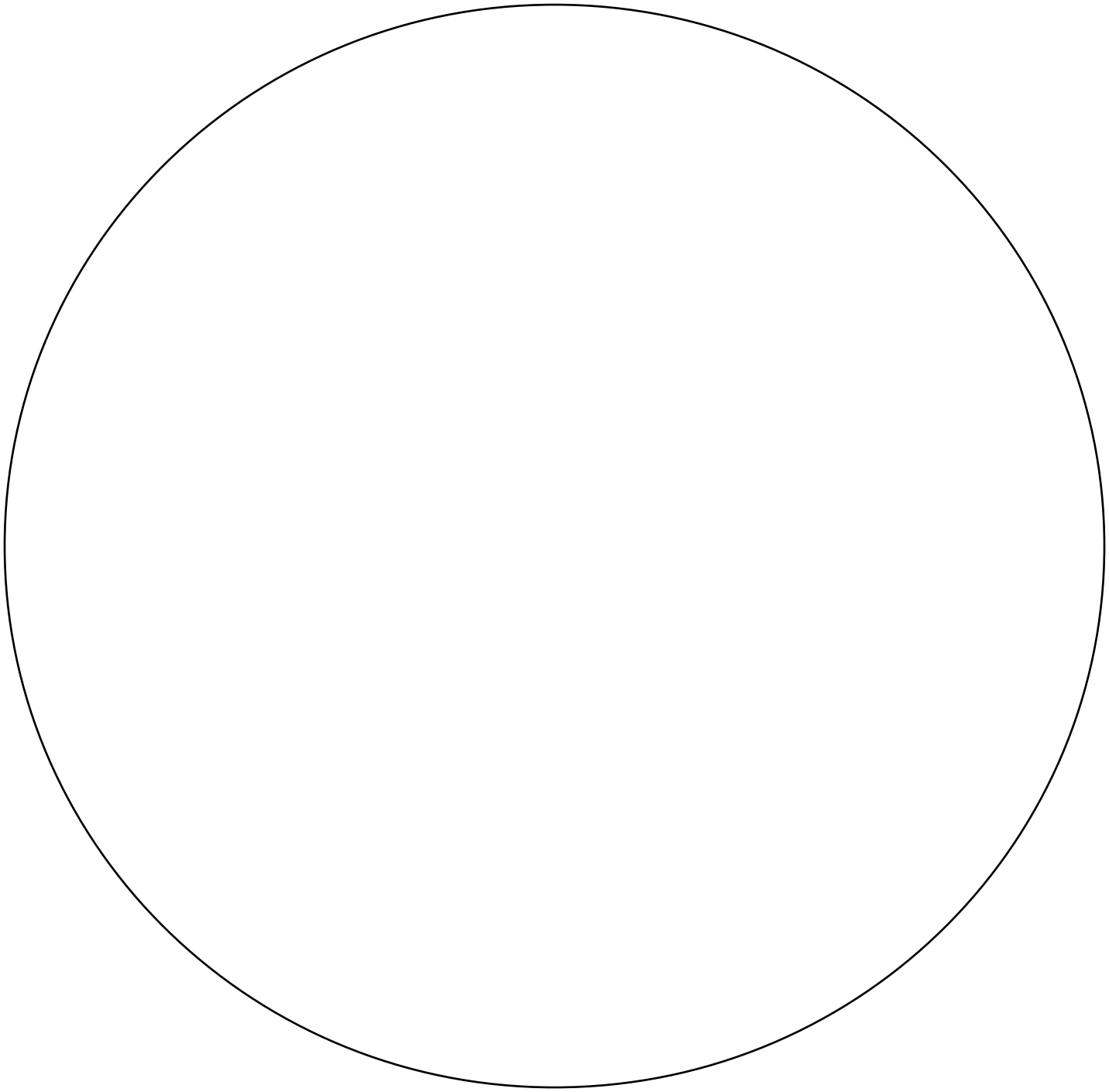
Scoring

- Score the clock based on the following six-point scoring system:
- Higher scores reflect a greater number of errors and more impairment. A score ≥ 3 represents a cognitive deficit.

Score	Error(s)	Examples
1	"Perfect"	No Errors in the Task
2	Minor Visuospatial Errors	a. Mildly impaired spacing of times b. Draws times outside circle c. Turns page while writing so that some numbers appear upside down d. Draws in lines (spokes) to orient spacing
3	Inaccurate representation of 10 after 11 when visuospatial organization is perfect or shows only minor deviations.	a. Minute hand points to 10 b. Writes "10 after 11" c. Unable to make any denotation of time
4	Moderate representation disorganization of times such that accurate denotation of 10 after 11 is impossible.	a. Moderately poor spacing b. Omits numbers c. Perseveration: repeats circle or continues on past 12 to 13, 14, 15, etc. d. Right-left reversal: numbers drawn counterclockwise e. Dysgraphia: unable to write numbers accurately
5	Severe level of disorganization as described in scoring of 4.	See examples of scoring of 4
6	No reasonable representation of a clock.	a. No attempt at all b. No semblance of a clock at all c. Writes a word or name

Clock Drawing Test

Patients Name _____Date _____



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Richardson HE, Glass JN. A comparison of scoring protocols on the clock drawing test in relation to ease of use, diagnostic group, and correlations with Mini-Mental State Examination. J Am Geriatr Soc. 2002;50:169-173

Shulman KI, Gold DP, Cohen CA, Zucchero CA. Clock drawing and dementia in the community: a longitudinal study. Int J Geriatr Psychiatry. 1993;8:487-496.

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Standardized Test Compendium

Dynamic Gait Index

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Dynamic Gait Index

Patient: _____Date: _____

1. Gait level surface____

Instructions
Walk at your normal speed from here to the next mark (20')

Grading
Mark the lowest category that applies.

(3) Normal: Walks 20', no assistive devices, good speed, no evidence for imbalance, normal gait pattern.
(2) Mild Impairment: Walks 20', uses assistive devices, slower speed, mild gait deviations.
(1) Moderate Impairment: Walks 20', slow speed, abnormal gait pattern, evidence for imbalance.
(0) Severe Impairment: Cannot walk 20' without assistance, severe gait deviations or imbalance.

2. Change in gait speed _____

Instructions
Begin walking at your normal pace (for 5'), when I tell you "go", walk as fast as you can (for 5'). When I tell you "slow", walk as slowly as you can (for 5').

Grading
Mark the lowest category that applies.

(3) Normal: Able to smoothly change walking speed without loss of balance or gait deviation. Shows a significant difference in walking speeds between normal, fast and slow speeds.
(2) Mild Impairment: Is able to change speed but demonstrates mild gait deviations, or no gait deviations but is unable to achieve a significant change in velocity, or uses an assistive device.
(1) Moderate Impairment: Makes only minor adjustments to walking speed, or accomplishes a change in speed with significant gait deviations, or changes speed but loses significant gait deviations, or changes speed but loses balance but is able to recover and continue walking.
(0) Severe Impairment: Cannot change speeds, or loses balance and has to reach for wall or be caught.

Dynamic Gait Index (continued)

3. Gait with horizontal head turns ____

Instructions

Begin walking at your normal pace. When I tell you to "look right," keep walking straight, but turn your head to the right. Keep looking to the right until I tell you, "look left," then keep walking straight and turn your head to the left. Keep your head to the left until I tell you "look straight," then keep walking straight, but return your head to the center.

Grading

Mark the lowest category that applies.

(3) Normal: Performs head turns smoothly with no change in gait.

(2) Mild Impairment: Performs head turns smoothly with slight change in gait velocity, i.e., minor disruption to smooth gait path or uses walking aid. (1) Moderate Impairment: Performs head turns with moderate change in gait velocity, slows down, staggers but recovers, can continue to walk.

(0) Severe Impairment: Performs task with severe disruption of gait, i.e., staggers, outside 15" path, loses balance, stops, reaches for wall.

4. Gait with vertical head turns _____

Instructions

Begin walking at your normal pace. When I tell you to "look up," keep walking straight, but tip your head up. Keep looking up until I tell you, "look down," then keep walking straight and tip your head down. Keep your head down until I tell you "look straight," then keep walking straight, but return your head to the center.

Grading

Mark the lowest category that applies.

(3) Normal: Performs head turns smoothly with no change in gait.

(2) Mild Impairment: Performs task with slight change in gait velocity, i.e., minor disruption to smooth gait path or uses walking aid.

(1) Moderate Impairment: Performs task with moderate change in gait velocity, slows down, staggers but recovers, can continue to walk.

(0) Severe Impairment: Performs task with severe disruption of gait, i.e., staggers, outside 15" path, loses balance, stops, reaches for wall.

Dynamic Gait Index (continued)

5. Gait and pivot turn ___

Instructions

Begin walking at your normal pace. When I tell you, ''turn and stop," turn as quickly as you can to face the opposite direction and stop.

Grading

Mark the lowest category that applies.

(3) Normal: Pivot turns safely within 3 seconds and stops quickly with no loss of balance.
(2) Mild Impairment: Pivot turns safely in > 3 seconds and stops with no loss of balance.
(1) Moderate Impairment: Turns slowly, requires verbal cueing, requires several small steps to catch balance following turn & stop.
(0) Severe Impairment: Cannot turn safely, requires assistance to tum and stop.

6. Step over obstacle _____

Instructions

Begin walking at your normal speed. When you come to the shoebox, step over it, not around it, and keep walking.

Grading

Mark the lowest category that applies.

(3) Normal: Is able to step over the box without changing gait speed, no evidence of imbalance.
(2) Mild Impairment: Is able to step over box, but must slow down and adjust steps to clear box safely.
(1) Moderate Impairment: Is able to step over box but must stop, then step over. May require verbal cueing. (0) Severe Impairment: Cannot perform without assistance.

7. Step around obstacles _____

Instructions

Begin walking at normal speed. When you come to the first cone (about 6' away), walk around the right side of it. When you come to the second cone (6' past first cone), walk around it to the left.

Dynamic Gait Index (continued)

Grading
Mark the lowest category that applies.

(3) Normal: Is able to walk around cones safely without changing gait speed; no evidence of imbalance.
(2) Mild Impairment: Is able to step around both cones, but must slow down and adjust steps to clear cones.
(1) Moderate Impairment: Is able to clear cones but must significantly slow speed to accomplish task, or requires verbal cueing.
(0) Severe Impairment: Unable to clear cones, walks into one or both cones, or requires physical assistance.

8. Steps _____

Instructions
Walk up these stairs as you would at home, i.e., using the railing if necessary. At the top, turn around and walk down.

Grading
Mark the lowest category that applies. (3) Normal: Alternating feet, no rail.
(2) Mild Impairment: Alternating feet, must use rail.
(1) Moderate Impairment: Two feet to a stair, must use rail.
(0) Severe Impairment: Cannot do safely.

TOTAL SCORE: /24

Scoring Information
- 21/24 or above= minimal to no risk for falls
- Below 21 indicates risk for falls and the lower the score the more the risk
- Common score for moderate stage Parkinson Disease= 9-11/24.

Resources
Fritz, S., & Lusardi, M. (2009). Walking speed: The sixth vital sign (white paper). Journal of Geriatric Physical Therapy, 32(2), 2-5. PubMed PMID: 20039582.

Standardized Test Compendium

Elderly Mobility Scale

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Elderly Mobility Scale

Purpose

To provide physiotherapists with a standardized validated scale for assessment of mobility in more frail elderly patients. The scale assesses 7 dimensions of functional performance; locomotion, balance and key position changes, all of which are intrinsic skills that permit the performance of complex activities of daily living.

Scoring

Total score is from a maximum of 20, higher scores indicate better performance.
Score totals:
14-20: Maneuvers lone and safely. Independent in basic ADLs. These patients are generally safe to go home but may need home help.
10-13: Borderline in terms of safe mobility and independence in ADLs. These patients will require some help with mobility maneuvers.
<10: dependent in mobility maneuvers and requiring help with basic ADLs (transfers, toileting, dressing, etc.) May require Home Care Package/Long Term Care depending on patients wishes and circumstances.

Note

These are general interpretations. They do not take into account cognition, safety awareness and other factors that may impact on mobility e.g. postural hypotension.

Elderly Mobility Scale (continued)

Lying to sitting 2- Independent 1-Needs help of 1 person 0- Needs help of 2+ people	**Gait** 3-Independent (Incl. use of stick) 2-Independent with frame 1-Mobile with walking aid but erratic/unsafe turning 0-Requires physical assistance or constant supervision
Sitting to lying 2- Independent 1-Needs help of 1 person 0- Needs help of 2+ people	**Timed Walk** 3-Under 15 seconds 2-16-30 seconds 1-Over 30 seconds
Sit to stand 3-Independent in under 3 seconds 2-Independent in over 3 seconds 1-Needs help of 1 person (verbal or physical 0-Needs help of 2+ people	**Functional Reach** 4-Over 20cm 2-10-20cm 1-Under 10cm or unable
Standing 3-stands without support and reaches within arm's length 2-Stands without support but needs help to reach 1-Stands, but requires support 0-Stands, only with physical support (one person) Support= uses upper limbs to steady self	
Total	

References:

Proser L et al (1997) Further validation of EMS for measurement of mobility of hospitalized elderly people Clinical Rehabilitation 11, 4, 338-343

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Standardized Test Compendium

Executive Function Performance Test

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Executive Function Performance Test

Purpose

This is a performance based test of cognitive function. This test takes a macro-level view of cognition. Functioning as a whole is examined as individuals perform an entire task. EFPT is a top down functional assessment test, was designed to examine total cognitive- integration and functioning in an environmental context. The EFPT will determine which executive functions are impaired, determine an individual's capacity for independent function, and determine the amount of assistance necessary for task completion.

General Information

The EFPT examines then execution of four basic tasks that are essential for self-maintenance and independent living simple cooking, telephone use, medication management, and bill payment. The EFOT assesses an individual's ability to complete the components of the tasks:

- Initiation of Task
- Execution of Task (requiring organization, sequencing, judgement and safety)
- Completion of Task

During each task, cognitive functions fluidly interact and co-occur. The rater observes task performance, focusing specifically on executive function. The level of cueing necessary to support task performances is recorded as a score. Thus, the score reflects the participant's capacity for executive function that has been observed during performance of each task. For example, if the individual is unable to initiate the task, the rater can determine that the executive function underlying initiation is defective and plan a strategy to address this deficit.

Table 1

Executive Function Component	Definition	Expected Behavior
Initiation	The advent of motor activity that commences a task.	The individual moves to the materials table to collect items needed for the task.
Execution	The proper completion of each step, consisting of three requirements: organization, sequencing, and safety and judgement.	The individual correctly retrieves and uses the items that are necessary for the task.

Executive Function Performance Test (continued)

Organization	The physical arrangement of the environment, tools and materials to facilitate efficient and effective performance of steps.	The individual correctly retieves and uses the items that are necessary for the task.
Sequencing	The coordination and proper ordering of the steps that comprise the task, requiring the proper allotment of attention to each step	The individual carries out the steps in an appropriate order, attends to each step appropriately, and can switch attention from one step to the next.
Judgement and Safety	The employment of reason and decision-making capabilities to intentionally avoid physical, emotionally, or financially dangerous situations.	The individual exhibits an awareness of danger by actively avoiding or preventing the creation of a dangerous situation.
Completion	The inhibition of motor performance driven by the knowledge that the task is finished.	The individual indicates that he/she is finished or moves away from the area of the last step.

Cueing Guidelines

- Unless the participant is in danger do not intervene until the participant shows he/she is struggling with the next step.
- If the person has difficulty with any aspect of the task, you must wait at least 10 seconds (to observe processing) before giving the participant a cue.
- Give two cues of each kind before progressing to the next cueing level.
- Give cues progressively from verbal guidance, gestural guidance, direct verbal guidance, then finally physical guidance.
- If the participant is still unable to perform a step in the task, the examiner should do the step for him/her, then the participant should be cued back to the next sequential step of the task.
- You will often find yourself combining different levels of cues. The score of your degree of assistance must reflect the highest level of cue used to get the task done.
- Do not initiate conversations during the test, do not give positive or negative feedback.

Executive Function Performance Test (continued)

No Cues Required	The participant required no help or reassurance, does not ask questions for clarification, goes directly to the task and does it.
Indirect Verbal Guidance	The person requires verbal prompting, such as an open- ended question or an affirmation that will help them move on. Indirect verbal guidance should come in the form of a questions. For example, “What is the next step?” or “What else do you need?”
Gestural Guidance	The person requires gestural prompting. At this level, you are not physically involved with any portion of the task. Instead you should make a gesticulation that mimics the action that is necessary to complete the subtask, or make a movement that guides the participant. For example, you may move your hands in a stirring motion or point to where the participant might find the item.
Direct Verbal Assistance	You are required to deliver a one-step command, so that you are cueing the participant to take an action. For example, “pick up the pen” or “pour the water into the pan.”
Physical Assistance	You are physically assisting the participant with the step, but you are not doing it for him/her. You may hold the cup while he/she pours, hold the check book while he/she writes, loosen the cap on the medicine container ect., but the participant is still attending to and participating in the task.
Do for the Participant	You are required to do the step for the participant.

Executive Function Performance Test (continued)

Equipment

All of these items are in a box, placed on a surface. The person needs to obtain the items they need for the task and place them outside of the box before beginning the task.

- Hand soap dispense
- Towel
- Pan
- Pot Holder
- Glass measuring cup- 1 cup
- Dry measuring cups
- Spoon for stirring
- Rubber spatula
- Old-fashioned Oats
- Enlarged copy of the instructions for the stovetop version only
- Bowl
- Spoon for eating
- Salt shaker
- Timer- a timer with a dial rather than a digital timer
- Pencil
- Paper
- Phone book
- Magnifying Glass
- Medicine bottle with instruction on it- with the person's name on it filled with sugar free candy
- Claritin bottle (nonprescription) as a distractor- filled with sugar free candy
- Drinking cup
- Two bills (one cable, one phone, with pre-addressed envelopes) mixed with 5 other pieces of mail (letter from credit card company, postcard, flier, letter in a plain white envelope, mail order catalog.) in a Ziploc bag
- Checks
- Balance sheet (i.e., account book) with a balance $5.00 less than the bills total
- Pen
- Ziploc bag
- Calculator
- Tongs
- Pepper shaker
- Catalog
- Restaurant/apartment guide

Executive Function Performance Test (continued)

Instructions

The tasks should be carried out in the following order

- Hand Washing (score sheet A)- One use if the person has severe cognitive impairment and you want to see if they can follow directions. If they cannot do the task do not proceed with administration. Do not score the handwashing task when reporting the scores in analysis.
- Oatmeal Preparation (score sheet B)
- Telephone (score sheet C)
- Taking Medication (score sheet D)
- Paying Bills (score sheet E)

- If the participant refused to do a particular task (except the hand washing), the task can be skipped and do later.

- Instructor says, "Today I'll be asking you to wash your hands, make some oatmeal, use the telephone, take some "fake'' medication, and pay some "fake" bill. You may not be doing these task· at home, but they have been selected for this test as representing those most like daily tasks. If you need help at any point in this test, let me know".
- "All the items you need to do these tasks are here in the box (show it to them). I want to know a few things about you before I begin the testing, so I'm going to ask you some questions. Please answer them as best as you can. This card should guide your responses (show the participant the response card and read directly from it)."

- Note: Offer assistance only after the participant has made a good attempt to process the actions necessary to carry out the step. The cueing guidelines should be used.
- Complete the cueing chart and behavior assessment chart for each task.

Pretest Questions

1. Will you be able to wash your hands?
   0=by yourself
   1=with verbal assistance
   2=with physical assistance
   3= won't be able to do this task

Executive Function Performance Test (continued)

2. Will you be able to make a phone call?
   0=by yourself
   1=with verbal assistance
   2=with physical assistance
   3= won't be able to do this task
3. Do you cook? - 1=Yes 2=No
4. Do you use a stove to cook? 1=Yes 2=No
5. Have you recently made oatmeal on the stove? 1=Yes 2=No
6. Will you be able to make oatmeal?
   0=by yourself
   1=with verbal assistance
   2=with physical assistance
   3= won't be able to do this task
7. Do you take medication? 1=Yes 2=No
8. Can you show me where you keep your medication? 1=Yes 2=No

9. When do you take your medication?
   1=Morning
   2=Afternoon
   3=Evening
   4=Before bed
   5=More than once a day
10. Will you be able to take medicine?
    0=by yourself
    1=with verbal assistance
    2=with physical assistance
    3= won't be able to do this task
11. Do you use a phone on a regular basis? 1=Yes 2=No
    How many times a week do you use the phone? _____
    What is the phone number you call in an emergency? _____ 1=Correct 2=Incorrect
12. Do you pay your bills? 1=Yes 2=No
    Does someone help you with your bills? 1=Yes 2=No
13. Will you be able to pay these bills?
    0=by yourself
    1=with verbal assistance
    2=with physical assistance
    3= won't be able to do this task

Executive Function Performance Test (continued)

Task 1- "I want to see you wash your hands with soap. The items you will need are in the box"
Form A

Task- hand Washing	Independent 0	Verbal Guidance 1	Gestural Guidance 2	Verbal Direct Instruction 3	Physical Assistance 4	Done for Participant 5	Score
Initiation: beginning the task							
Upon request to start participant moves to table to gather tools/materials to wash hands.							
Execution: carrying out the actions of the task through the use of organization, sequencing, and judgement							
Organization: arrangement of the tools/materials to complete the task (patient retrieves the items needed)							
Sequencing: execution of steps in the appropriate order.							
Judgement and safety: avoidance of dangerous situations such as water temperature too hot, tries to eat soap. Etc..							
Completion: termination of task							
Participant knows he/she is finished							

Total Score_____

Executive Function Performance Test (continued)

Task 2: Simple Cooking "I want you to make oatmeal. Here is an enlarged version of the instructions (hand to participant). Follow these directions and when you are done, put the oatmeal in a bowl. The items you need are in the box"
Form B

Task- Simple Cooking	Independent 0	Verbal Guidance 1	Gestural Guidance 2	Verbal Direct Instruction 3	Physical Assistance 4	Done for Participant 5	Score
Initiation: beginning the task							
Upon request to start participant moves to table to gather tools/materials for making oatmeal.							
Execution: carrying out the actions of the task through the use of organization, sequencing, and judgement							
Organization: arrangement of the tools/materials to complete the task (patient retrieves the items needed)							
Sequencing: execution of steps in the appropriate order.							
Judgement and safety: avoidance of dangerous situations such as forgets to use pot holder, spills pot of water. etc..							
Completion: termination of task							
Participant knows he/she is finished							

Total Score_____

Executive Function Performance Test (continued)

Task 3: Using the telephone: "I want you to look up a local grocery store in the phone book, telephone them, and ask them if they deliver groceries. Let me know what you find out. The items you need are in the box."
Form C

Task- Using the telephone	Independent 0	Verbal Guidance 1	Gestural Guidance 2	Verbal Direct Instruction 3	Physical Assistance 4	Done for Participant 5	Score
Initiation: beginning the task							
Upon request to start participant moves to table to gather tools/materials for making a phone call.							
Execution: carrying out the actions of the task through the use of organization, sequencing, and judgement							
Organization: arrangement of the tools/materials to complete the task (patient retrieves the items needed)							
Sequencing: execution of steps in the appropriate order.							
Judgement and safety: avoidance of dangerous situations such as dials wrong number, doesn't hang up phone etc..							
Completion: termination of task							
Participant knows he/she is finished							

Total Score_____

Executive Function Performance Test (continued)

Task 4

Taking Medication- "I need you to pretend you have a prescription in the box. Find your prescription and do what the instructions tell you to do. The pills in the bottle are safe, they are sugar-free candy." **Note:** it is okay if they chew the pill

After they take the drug, ask the following questions in order to rate judgement and safety:

1. What times during the day are you supposed to take this medicine?
   _____
   _____
2. What are you supposed to take with this medication?
   _____
   _____
3. What do you need to be careful of when you take this medication?
   _____
   _____

Executive Function Performance Test (continued)

Task 5: "I need you to pretend you have a prescription in the box. Find your prescription and do what the instructions tell you to do. The pills in the bottle are safe, they are sugar-free candy."

Form D

Task- Taking Medication	Independent 0	Verbal Guidance 1	Gestural Guidance 2	Verbal Direct Instruction 3	Physical Assistance 4	Done for Participant 5	Score
Initiation: beginning the task							
Upon request to start participant moves to table to gather tools/materials for taking medication.							
Execution: carrying out the actions of the task through the use of organization, sequencing, and judgement							
Organization: arrangement of the tools/materials to complete the task (patient retrieves the items needed)							
Sequencing: execution of steps in the appropriate order.							
Judgement and safety: avoidance of dangerous situations such as takes the wrong number of pills, spills water, Ect.							
Completion: termination of task							
Participant knows he/she is finished							

Total Score_____

Executive Function Performance Test (continued)

Task 5: Paying Bills- "I want you to take what you need to pay the bills out of the bag, find the bills, pay them and balance the account. These are fake bills and this is not your account but I need you to pretend that these are your bills and your account as this is part of the assessment."

Form E

Task- Using the telephone	Independent 0	Verbal Guidance 1	Gestural Guidance 2	Verbal Direct Instruction 3	Physical Assistance 4	Done for Participant 5	Score
Initiation: beginning the task							
Upon request to start participant moves to table to gather tools/materials for paying bills.							
Execution: carrying out the actions of the task through the use of organization, sequencing, and judgement							
Organization: arrangement of the tools/materials to complete the task (patient retrieves the items needed)							
Sequencing: execution of steps in the appropriate order.							
Judgement and safety: avoidance of dangerous situations such as writing two checks, not subtracting amount etc..							
Completion: termination of task							
Participant knows he/she is finished							

Total Score_____

Executive Function Performance Test (continued)

Scoring: The highest level of cueing necessary to support the performance of the four instrumental tasks (handwashing is not scored as it is a screening tool) is recorded; thus, the test results in three scores, the executive function (EF) component score, the task score, and a total overall score. The EF component score is calculated by summing the numbers recorded on each of the four tasks for initiation, organization, sequencing, judgment and completion. Each EF component can range from 0 to 5 with a total of all four tasks ranging from 0-20. The second score is the task score; this is calculated by summing the five scores for each task. The range for each task is 0 to 25. The total score is the sum of the performance on all four tasks with a total score of performance on all four tasks that can range from 0 to 100.

Standardized Test Compendium

Function in Sitting Test

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Function in Sitting Test

Purpose

- The Function in Sitting Test, or FIST, is a 14 item, performance-based, clinical examination of sitting balance.

Equipment

- Step stool or riser (for foot positioning, dependent on patient height)
- Stopwatch or watch with second hand, for timing
- Tape measure
- Small, lightweight object (can use small, retractable tape measure or stopwatch for this)
- FIST scoring sheet

General Information

- The FIST was designed to be administered at the hospital bedside by a physical therapist or other health care provider. It should take approximately five to ten minutes to administer. This may vary depending on the need to reposition the patient and the patient's needs for redirection or rest breaks. Patients are asked to perform basic, everyday activities in a seated position with an examiner scoring their performance using a 0-4-point ordinal scale. For ease of scoring, the scoring scale is the same for each test item.
- Standard Patient Position:
    - This position should be maintained throughout the test. The examiner should realign the patient as needed before each test item to ensure that the patient starts in this standard position.
    - Patient seated at edge of standard hospital bed (no overlay or specialized air mattresses), with bed flat.
    - ½ of femur length supported by mattress while sitting.
    - Hips and knees flexed to 90 degrees
    - Feet flat in support on the floor (or on a step or stool, as needed) to ensure proper hip and knee position.
    - Thighs should be positioned in neutral hip abduction/adduction and hip internal/external rotation (or as close as the patient's hip range of motion will allow.
    - Hands in lap, unless needed for balance support (see scoring if subject uses upper extremities or hands for support.

Function in Sitting Test (continued)

Instructions

- Anterior nudge
  (light pressure x 1 time, at sternum)
  Without warning, push participant with light pressure, once.
- Posterior nudge
  (light pressure x 1 time, between scapular spines)
  Without warning, push participant with light pressure, once.
- Lateral nudge
  (light pressure 1 time to dominant/stronger side, at acrominon)
  Without warning, push participant with light pressure, once only, at dominant/stronger side's acrominon.
- Static sitting
  "Sit with your hands in your lap."
  Examiner times for 30 seconds.
- Sitting, move head side to side (nod 'no')
  "Remain sitting steady and tall without using your hands unless you need them to help you balance. When I tell you to 'look right,' keep sitting straight, but turn your head to the right. Keep looking to the right until I tell you 'look left,' then keep sitting straight and turn your head to the left. Keep your head to the left until I tell you, 'look straight,' then keep sitting straight but return your head to the center."
  Patient needs to move head through full available ROM. Examiner scores entire sequence.
- Sitting, eyes closed
  "Close your eyes and remain sitting still with your hands in your lap."
  Examiner times for 30 seconds.
- Sitting, lift feet
  (dominant side, stronger side, least involved side only; do two repetitions)
  "Sit with your hands in your lap; lift your [uninvolved side] foot 1 inch off the floor, like this. [Demonstrate] Now do it one more time." Repeat so the subject lifts uninvolved, stronger, or dominant side twice.
- Turn and pick up object from behind in preferred direction
  "Turn around and pick up the object that I've placed behind you." Patient may turn to their preferred direction and use their stronger/dominant/least involved hand. Examiner places object in midline, one hand's breadth [fingertip to base of palm] posterior to hips.
- Reach forward with uninvolved hand outstretched at shoulder height
  "Reach with your stronger/least involved/less painful arm as far as you can while staying balanced, like this. [Demonstrate] Keep your other hand remaining in your lap."
  Examiner first performs movement passively to assess ROM. Patient must move through full available ROM or until abdomen contacts anterior thighs for highest score. Use available pain free ROM. If patient has pain, and make notation in Notes/Comments box.

Function in Sitting Test (continued)

- Lateral reach with hand at shoulder height
  (lifts and moves towards the dominant or stronger side)
  "Reach out to the side as far as you can. Be sure to get all your weight off the opposite side of your bottom keeping your feet on the floor, like this. [Demonstrate] "
  Patient must complete full, available ROM maintaining upright upper trunk and upper extremity position, with contralateral trunk shortening and clearance of contralateral ischial tuberosity and return to midline for full score. Should move to preferred side, stronger side, or least affected side.
- Pick object up off floor
  "Pick this object up off the floor."
  Examiner places object between patient's feet at level of 1st MTP joint.
  Patient can use whatever hand they prefer to pick up the object.
- Posterior scooting (2")
  "Now, move backward 2 inches. Try not to use your hands, if you can."
  Patient needs to move full 2 inches. Use tape measure to verify 2 inches.
- Anterior scooting (2")
  "Move forward 2 inches towards the edge of the bed without using your hands, if possible."
  Use tape measure to verify 2 inches. Patient needs to move full 2 inches.
- Lateral scooting (2")
  (scored once to preferred direction)
  "Move sideways 2 inches without your hands, and remember to try not to use your hands." Patient needs to move the full 2 inches; use the tape measure to verify.

References

Function in Sitting Test (FIST) Training and Instruction Manual (Version 1.5; 5/20/11. Developed and Created by Sharon L. Gorman, PT, DPTSc, GCS

Standardized Test Compendium

Functional Reach Test

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Functional Reach Test

Purpose

- The Functional Reach Test assesses a patient's stability by measuring the maximum distance an individual can reach forward while standing in a fixed position. The modified version of the Functional Reach Test requires the individual to sit in a fixed position.

General Information

- The Functional Reach test can be administered while a patient is standing (functional Reach) or sitting (Modified Functional Reach)

Equipment

- Yard Stick; the yardstick should be affixed to the wall at the level of the patient's acromion.
- Duct Tape

Functional Reach Instructions

- Patient is instructed to stand next to a wall without touching it, and position the arm that is closer to the wall at 90 degrees of shoulder flexion with a closed fist.
- The assessor records the starting position at the 3rd metacarpal head on the yardstick.
- Instruct the patient to "reach as far as you can forward without taking a step."
- Record the location of the 3rd metacarpal
- Scores are determined by assessing the difference between the start and end position is reach distance, usually measured in inches.
- Three trials are done and the average of the last two is noted.

Modified Functional Reach Test

- Performed with a leveled yardstick that has been mounted on the wall at the height of the patient's acromion level in the non-affected arm while sitting in a chair.
- Hips, knees and ankles positioned are at a 90 degree of flexion, with feet positioned flat on the floor.
- The initial reach is measured with the patient sitting against the back of the chair with the upper-extremity flexed at 90 degrees, measure was taken from the distal end of the third metacarpal along the yardstick.
- Consists of three conditions over three trials:
  1. Sitting with the unaffected side near the wall and leaning forward
  2. Sitting with the back to the wall and leaning right
  3. Sitting with the back to the wall leaning left
- Instructions should include learning as far as possible in each direction without rotation and without touching the wall.

Functional Reach Test (continued)

- Record the distance in centimeters covered in each direction.
- If the patient is unable to raise the affected arm, the distance covered by the acromion during leaning is recorded.
- First trial in each direction is a practice trial and should not be included in the final result
- A 15 second rest break should be allowed between trials

References

Duncan, P.W., D.K. Weiner, et al. (1990). "Functional reach: a new clinical measure of balance." Gerontol 45(6): M192-197.

Katz-Leurer, M., I. Fisher, et al. (2009). "Reliability and validity of the modified functional reach test at the sub-acute stage post-stroke." Disabil Rehabil 31(3): 243-248.

Weiner, D.K., D. R. Bongiorni, et al/ (1993). "Does functional reach improve with rehabilitation?" Arch Phys Med Rehabil 74(8): 796-800.

Weiner, D. K., P.W. Duncan, et al. (1992). "Functional reach: a marker of physical frailty." J Am Geriatr Soc 40(3): 203-207.

Standardized Test Compendium

Gait Speed Velocity Test

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Gait Speed Velocity Test

Purpose

The gait speed test is designed to assess the functional mobility of an individual. It is simple to perform, requires little space and equipment, small amount of time, and can be performed with various levels of ability/diagnosis. The gait speed has been used as a predictor of decline in functional mobility.

Equipment

- Stop watch
- Distance measured 3-10 meters

General Information

- Gait speed has been described as the time one takes to walk a specified distance on level surfaces over a short distance. This is not a measure of endurance.
- A distance of 3-10 meters is measured over a level surface with 2 meters for acceleration and 2 meters for deceleration.
- The subjects are asked to walk at their comfortable (normal/natural) speed over the entire distance (referred to as comfortable speed).
- The subjects are asked to walk as fast as they can (without running) over the same distance (referred to as maximum speed).
- The subjects are timed once the first foot passes the acceleration path and the time is stopped once the first foot enters the deceleration path.
- Two trials are given for each, with the average comfortable speed calculated and the average maximum speed calculated.
- Time to administer 5 min.

References:

https://www.sralab.org/rehabilitation-measures/gait-speed

Standardized Test Compendium

Instrumental Activities of Daily Living Scale

IADL

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Instrumental Activities of Daily Living Scale (IADL)

Ability to use telephone

1. Operated telephone on own initiative; looks up and dials numbers: (1)___
2. Dials a few well-known numbers: (1)___
3. Answers the telephone but does not dial: (1)___
4. Does not use the telephone at all: (0)___

Shopping

1. Takes care of all shopping needs independently : (1)___
2. Shops independently for small purchases: (0)___
3. Needs to be accompanied on any shopping trip: (0)___
4. Completely unable to shop: (0)___

Food Preparation

1. Plans, prepares and serves adequate meals independently: : (1)___
2. Prepares adequate meals if supplied with ingredients: (0)___
3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet: (0)___
4. Needs to have meals prepared and served: (0)___

Housekeeping

1. Maintains house alone or with occasional assistance (heavy work): (1)___
2. Performs light daily tasks such as dishwashing, bed making: (1)___
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness (1)___
4. Needs help with all home maintenance tasks: (1)___
5. Does not participate in any housekeeping tasks: (0)___

Laundry

1. Does personal laundry completely: (1)___
2. Launders small items, rinses stockings, ect. (1)___
3. All laundry must be done by others: (0)___

Mode of Transportation

1. Travels independently on public transportation or drives own car: (1)___
2. Arranges own travel via taxi, but does not otherwise use public transfortation: (1)___
3. Travels on public transportation when accompanied by another: (1)___
4. Travel limited to taxi or automobile with assistance of another: (0)___
5. Does not travel at all: (0)___

Instrumental Activities of Daily Living Scale (IADL) (continued)

Responsibility for own medications

1. Is responsible for taking medication in correct dosages at correct time: (1)___
2. Takes responsibility if medication is prepared in advance in separate dosage: (0)___
3. Is not capable of dispensing own medication: (0)___

Ability to handle finances

1. Manages financial matters independently: (1)___
2. Manages day-to-day purchases, but needs help with banking, major purchases (1)___
3. Incapable if handling money: (0)___

References:

Lawton, M.P. and Brody, E.M. "Assessment of older people: Self-maintaining and instrumental activities of daily living." Gerontologist 9:179-186, (1969).

Standardized Test Compendium

The Kettle Test

A Cognitive Functional Screening Test

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The Kettle Test
A Cognitive Functional Screening Test

Description
The client is asked to prepare two hot beverages that differ in two ingredients.

Equipment
- Electric Kettle completely disassembled. It is important to use a kettle where the lid and cord come apart so the client must assemble the kettle before use.
- Ingredients for the beverages on one tray together with other ingredients as distracters. (examples: salt, pepper, oil, butter).
- Dishes and utensils together in one place with distracters. (examples: 3 cups, can opener, plate, 3 spoons, fork).

Instructions
- Instructor says: "I am going to ask you to prepare 2 cups of hot beverages. This is a performance test that is intended to give me an idea how you are performing daily tasks. I will observe while you are doing this task. Now we will make the decisions and agreement about the details of the task. Your task is to prepare 2 cups of hot drink, one for you and one for me. You can choose from regular instant coffee, decaffeinated coffee, and many kinds of teas. You can add a sweetener (sugar or artificial sweetener) and milk. Now tell me, what would you like to drink?"
- If the client wants to prepare a beverage for him/her self, determine the details of his/her drink, and then ask for another drink that differs in 2 ingredients from that of the client (example: if he/she wants coffee with milk, you could ask for tea with one artificial sweetener). You should make sure that at least one drink includes milk. If the client does not want a drink, ask him/her to prepare a beverage that he/she usually drinks even if he/she does not want to drink it now.
- Before starting the test: Ask the client to repeat the instructions until you verify that he/she knows the details of the task and understands them. If he/she gets it wrong repeat the instructions. Don't start until the client can repeat the instructions correctly (unless the client has a documented language disorder).

The Kettle Test
A Cognitive Functional Screening Test (continued)

- During the task, you (the examiner) stand by within reaching distance from the client for safety precautions (close enough for intervention if necessary) and observe the client's performance **without** any cueing or intervention (verbal or physical) unless one of the following situations occur:
  a. Performance is unsafe for the client or the environment (for example, mishandling electricity, turning on kettle without water, pouring hot water in an unsafe manner etc.)
  b. Task progression is stopped: client does not give any indication of action for more than a minute (not including the appropriate waiting time for the water to boil).
  c. Client demonstrates repeated failure (e.g. cannot put lid on the body of the kettle) or requests assistance and is unable to progress independently with task steps.

Cueing procedure- if required (a, b, or c as described above):

- General cue, that does not give specific information about the performance or details of the task. Usually, in the format of a general question, such as: "what do you have to do now?"; "what is the next step?"; "what else do you need?" etc.
- Specific cue, that guides the client to take specific steps or delineates details of the task, such as: "now you have to turn on the kettle," "the faucet remained open," "the spoon is in the utensil holder," etc.
- Physical demonstration or assistance, such as demonstrating how to connect the electric cord to the body of the kettle, or assisting the client in turning off the faucet.

Post Test

The examiner notes the process that took place and after asks the client to recall the instructions and the process. Ask the client to rate his/her performance and the lever of difficulty he/she experienced in performing the task.

The Kettle Test
A Cognitive Functional Screening Test (continued)

Examiner Notes

Description of the process by the examiner:

_____
_____
_____
_____

Recall of the instructions by the client. "What were the steps you had to take?"

_____
_____
_____
_____

The client's description of the process. "Describe what you had to do from beginning to end."

_____
_____
_____
_____

Rating of performance by the client. "How do you rate your performance on this task between 0-10?" or …." very good", "fair", "not so good" or "not good at all".

_____

Rating of difficulty by the client. "how difficult was the task for you? Easy, a little difficult, or very difficult."

_____

Additional Comments:

_____
_____
_____
_____

The Kettle Test
A Cognitive Functional Screening Test (continued)

Scoring Instructions

- There are 13 steps of the task to be scored. Each step will be scored 0-4.
  0= Intact performance
  1= slow and/or trial and error; and/or questionable performance but completes independently
  2= Received general cues
  3=
    a. Received specific cueing.
    b. Incomplete performance (for example only put part of the ingredients in the cups, lifts the kettle before water boils) or deficient performance (for example puts cover upside down, Omitted a step)
  4= Received physical demonstration or assistance

Scoring

Step:	Score 0-4	Comments
Opening the water faucet		
Filling the kettle with about 2 cups of water		
Turing off the faucet		
Assembling the kettle		
Attaching the electric cord to kettle		
Plugging the electric cord into electric socket		
Turning on the kettle		
Assembling the ingredients		
Putting the ingredients into the cups		
Picking up the kettle when water boils		
Pouring the water into the cups		
Adding milk		
Indication of task completion (verbal, gesture, serving?		
Total score (0-52)		

Note- If a cue was given, indicate why and what cue was given in the comments column

Standardized Test Compendium

MAM 20 Musculoskeletal

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MAM-20 For Patients with Musculoskeletal Conditions

Patient_____DOB_____Gender_____Dx_____ Date_____

Dominant Hand: ____Right ____Left ___Both Affected Hand: _____Right _____Left _____Both

Any Surgery Done to the Hand(s)? Yes_____ No_____ If so, date_____

0= N/A	1= cannot do	2= Very hard to do	3= A little hard to do	4= Easy to do
Almost never do the task, even before I had my condition	Impossible for me to do it	I usually ask others to do it for me unless no one is around to help me	I can do it, but it requires longer time and effort; sometimes it gives me pain/discomfort, or makes me tired	No problem. I can do it easily.

How easy or how hard for you to do the following tasks regardless which hand you use and without using an adaptive equipment? Choose only one number from above:

Wringing a towel		Brush or comb hair	
Open a medicine bottle with a child proof cap/top		Wash hands	
Cut nails with a nail clipper		Zip jacket	
Open a wide-mouth bottle previously opened		Write 3-4 lines legibly	
Cut meat on a plate		Turn Key	
Tie shoes with laces		Take things/cards out of a wallet	
Button clothes (medium sized buttons		Squeeze toothpaste onto a toothbrush	
Pick up ½ full pitcher of water		Handle/count money (bills and coins)	
Use spoon or fork		Brush teeth	
Dial or key in telephone numbers		Use hand(s) to eat a sandwich	

How much pain do you have in a typical day? Please indicate your pain on the average with a 0-10 scale. 0= no pain 10= Severe pain _____

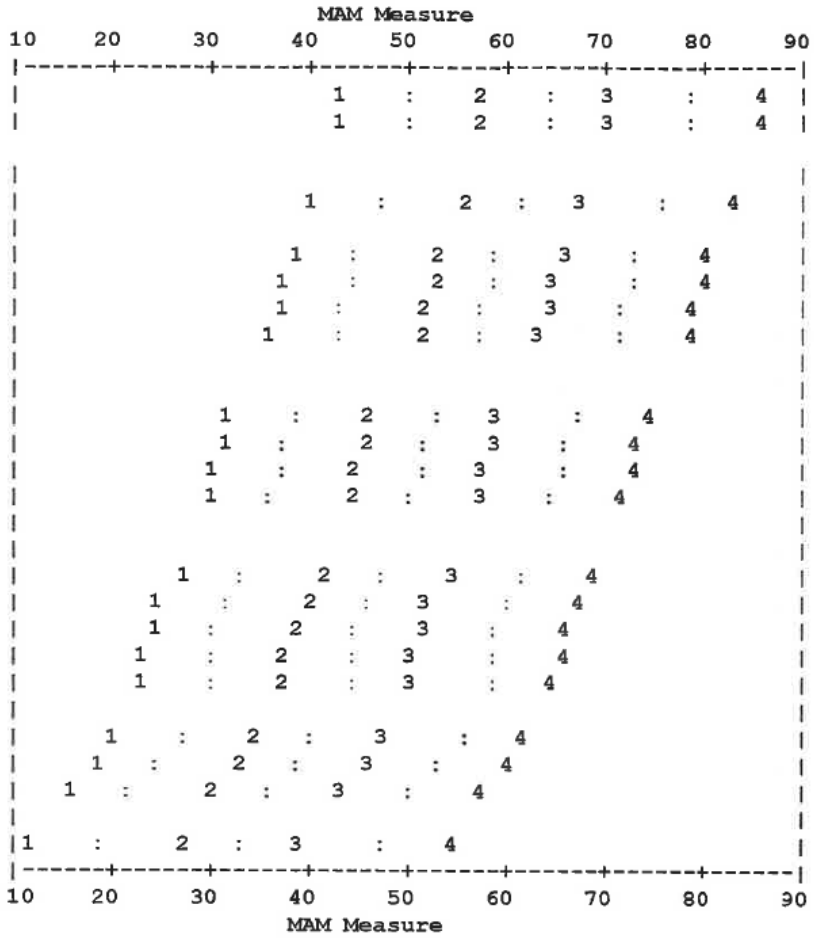
MAM-20 For Patients with Musculoskeletal Conditions (continued)

Scoring

Patient_____DOB_____Gender_____Dx_____ Date_____

Dominant Hand: ____Right ____Left ___Both Affected Hand: _____Right _____Left _____Both

0= N/A	1= cannot do	2= Very hard to do	3= A little hard to do	4= Easy to do



Tasks
wring a towel
open medicine bottle with a child proof cap/top
cut nails with a nail clipper
open a wide-mouth jar previously opened
cut meat on a plate
tie shoes with laces
button clothes (medium sized buttons)
pick up a ½ full water pitcher
zip a jacket
write 3-4 sentences legibly
turn key (to open a door)
take cards out of a wallet
squeeze toothpaste onto a toothbrush
count/handle money ((bills and coins)
brush or comb hair
wash hands
use a spoon or fork
brush teeth
dial or key in telephone numbers
eat a sandwich

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MAM-20 For Patients with Musculoskeletal Conditions (continued)

Scoring

In order to use the conversion table below, all items should have a rating. If a patient leaves items unanswered, you should ask him/her to explain and then try to put in a rating. However, if you absolutely don't have any other information on the patient, you can estimate the missing ratings based on the ratings from the adjacent items on the Key Form.

1. Circle all the ratings from the MAM-20 form to the Key Form; if necessary, estimate ratings for the missing data: these are your observed rating.
2. Add up all the ratings to derive patient's "sum score" (also listed in the 1st, 3rd, and 5th columns of the following conversion table)
3. Next, find the equivalent Rasch-derived (0-100) "MAM Measure" in the 2nd, 4th, and 6th columns.
4. Go to "key form". Notice that the MAM Measures are indicated at the top and bottom of the Key Form.
5. Draw a vertical line in the Key Form that corresponds to the "MAM Measure": these are your expected ratings.
6. Next, compare the observed ratings to the expected ratings.

MAM-20 For Patients with Musculoskeletal Conditions (continued)
Scoring

Sum Score	MAM Measure	Sum Score	MAM Measure	Sum Score	MAM Measure
20	0				
21	10.5	41	43.4	61	58.8
22	16.7	42	44.2	61	59.4
23	20.5	43	45.0	63	60.2
24	23.3	44	45.7	64	61.1
25	25.5	45	46.5	65	62
26	27.4	46	47.2	66	62.9
27	29.0	47	48	67	63.9
28	30.5	48	48.7	68	65.0
29	31.8	49	49.4	69	66.1
30	33.1	50	50.2	70	67.2
31	34.2	51	50.9	71	68.5
32	35.3	52	51.6	72	69.8
33	36.4	53	52.4	73	71.3
34	37.4	54	53.1	74	72.9
35	38.3	55	53.9	75	74.8
36	39.2	56	54.6	76	77.1
37	40.1	57	55.4	77	79.8
38	41.0	58	56.1	78	83.6
39	41.8	59	56.9	79	90.0
40	42.6	60	57.7	80	100

Standardized Test Compendium

MAM 20 Neurological

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MAM-20 For Patients with Neurologic Conditions

Patient_____DOB_____Gender_____Dx_____ Date_____
Dominant Hand: ____Right ____Left ___Both Affected Hand: _____Right _____Left _____Both
Any Surgery Done to the Hand(s)? Yes_____ No_____ If so, date_____

0= N/A	1= cannot do	2= Very hard to do	3= A little hard to do	4= Easy to do
Almost never do the task, even before I had my condition	Impossible for me to do it	I usually ask others to do it for me unless no one is around to help me	I can do it, but it requires longer time and effort; sometimes it gives me pain/discomfort, or makes me tired	No problem. I can do it easily.

How easy or how hard for you to do the following tasks regardless which hand you use and without using an adaptive equipment? Choose only one number from above:

Wringing a towel		Brush or comb hair	
Open a medicine bottle with a child proof cap/top		Wash hands	
Cut nails with a nail clipper		Zip jacket	
Open a wide-mouth bottle previously opened		Write 3-4 lines legibly	
Cut meat on a plate		Turn Key	
Tie shoes with laces		Take things/cards out of a wallet	
Button clothes (medium sized buttons		Squeeze toothpaste onto a toothbrush	
Pick up ½ full pitcher of water		Handle/count money (bills and coins)	
Use spoon or fork		Brush teeth	
Dial or key in telephone numbers		Use hand(s) to eat a sandwich	

How much pain do you have in a typical day? Please indicate your pain on the average with a 0-10 scale. 0= no pain 10= Severe pain

_____

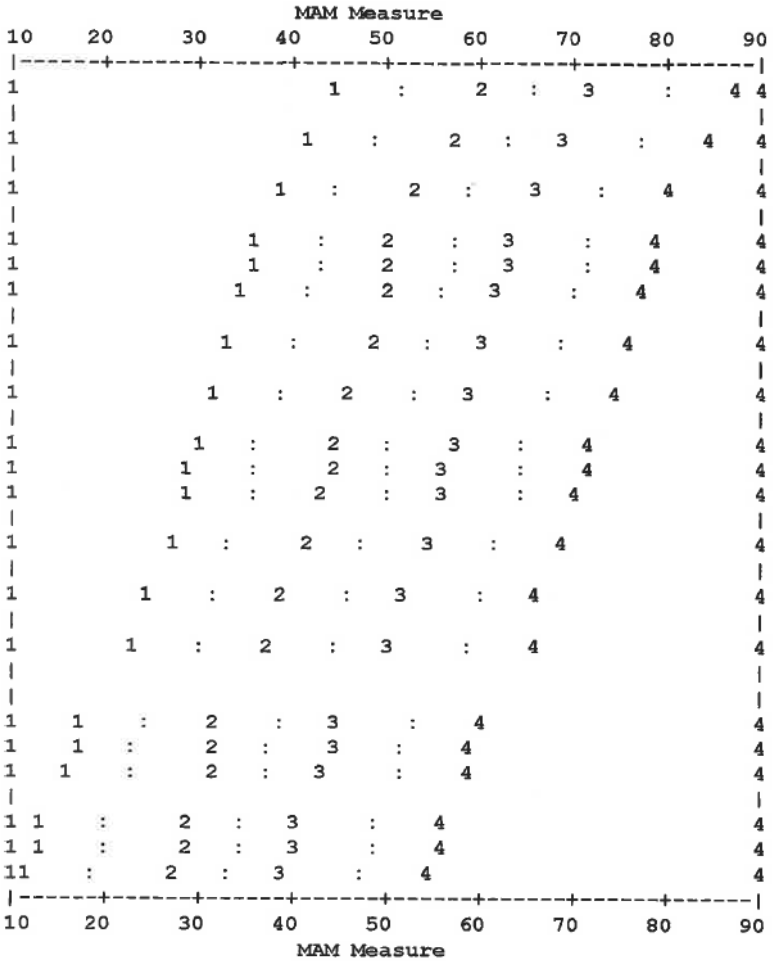
MAM-20 For Patients with Neurologic Conditions (continued)

Scoring

Patient_____DOB_____Gender_____Dx_____ Date_____

Dominant Hand: ____Right ____Left ___Both Affected Hand: _____Right _____Left _____Both

0= N/A	1= cannot do	2= Very hard to do	3= A little hard to do	4= Easy to do



Tasks
cut nails with a nail clipper
tie shoes with laces
cut meat on a plate
wring a towel
open medicine bottle with a child proof cap/top
zip a jacket
button clothes
write 3-4 sentences legibly
take things out of a wallet
open a jar previously opened
handle or count money (bills and coins)
pick up a ½ full water pitcher
turn key (to open a door)
squeeze toothpaste onto a toothbrush
use a spoon or fork
comb or brush hair
dial or key in telephone or cell phone
brush teeth
wash hands
eat a sandwich

MAM-20 For Patients with Neurologic Conditions (continued)

Scoring

In order to use the conversion table below, all items should have a rating. If a patient leaves items unanswered, you should ask him/her to explain and then try to put in a rating. However, if you absolutely don't have any other information on the patient, you can estimate the missing ratings based on the ratings from the adjacent items on the Key Form.

1. Circle all the ratings from the MAM-20 form to the Key Form; if necessary, estimate ratings for the missing data: these are your observed rating.
2. Add up all the ratings to derive patient's "sum score" (also listed in the 1st, 3rd, and 5th columns of the following conversion table)
3. Next, find the equivalent Rasch-derived (0-100) "MAM Measure" in the 2nd, 4th, and 6th columns.
4. Go to "key form". Notice that the MAM Measures are indicated at the top and bottom of the Key Form.
5. Draw a vertical line in the Key Form that corresponds to the "MAM Measure": these are your expected ratings.
6. Next, compare the observed ratings to the expected ratings.

MAM-20 For Patients with Neurologic Conditions (continued)

Scoring

Sum Score	MAM Measure	Sum Score	MAM Measure	Sum Score	MAM Measure
20	0				
21	9.7	41	43.1	61	58.7
22	15.9	42	43.9	61	59.6
23	19.7	43	44.7	63	60.5
24	22.5	44	45.5	64	61.4
25	24.7	45	46.3	65	62.3
26	26.6	46	47.1	66	63.3
27	28.3	47	47.8	67	64.3
28	29.8	48	48.6	68	65.3
29	31.1	49	49.3	69	66.4
30	32.4	50	50.1	70	67.6
31	33.6	51	50.9	71	68.9
32	34.7	52	51.6	72	70.2
33	35.8	53	52.4	73	71.8
34	36.8	54	53.1	74	73.4
35	37.8	55	53.9	75	75.4
36	38.7	56	54.7	76	77.6
37	39.6	57	55.5	77	80.4
38	40.5	58	56.3	78	84.3
39	41.4	59	57.1	79	90.0
40	42.3	60	57.9	80	100

Standardized Test Compendium

Mini Mental Status Examination

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Mini Mental Status Examination

Purpose

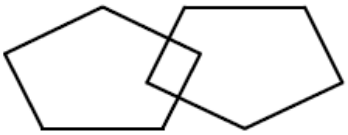
- The Mini-Mental Status Examination offers a quick and simple way to quantify cognitive function and screen for cognitive loss. It tests the individual's orientation, attention, calculation, recall, language and motor skills.

Equipment

- None

General Information

- Ask questions:
  - "What is the year? Season? Date? Day? Month?"
  - "Where are we now? State? County? Town/city? Hospital? Floor?"
  - The examiner names three unrelated objects clearly and slowly, then the instructor asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible.
  - "I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, …) Alternative: "Spell WORLD backwards." (D-L-R-O-W)
  - "Earlier I told you the names of three things. Can you tell me what those were?"
  - Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
  - "Repeat the phrase: 'No ifs, ands, or buts.'"
  - "Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
  - "Please read this and do what it says." (Written instruction is "Close your eyes.")
  - "Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
  - "Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)



Mini Mental Status Examination (continued)

Instructions

- To give the examination, seat the individual in a quiet, well-lit room. Ask him/her to listen carefully and to answer each question as accurately as he/she can.
- Each section of the test involves a related series of questions or commands. The individual receives one point for each correct answer.
- Don't time the test but score it right away. To score, add the number of correct responses. The individual can receive a maximum score of 30 points.

References

Folstein MF, Folstein SE, McHugh PR: “Mini-mental state: A Practical method for grading the cognitive state of patients for the clinician.” J Psychiatr Res 1975; 12:189-198.

Standardized Test Compendium

Physical Performance Test

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Physical Performance Test

Purpose:

- The Physical Performance Test assesses multiple domains of physical function using observed performance of tasks that simulate activities of daily living of various degrees of difficulty in elderly persons.

Instructions

- Administer the test as outlined below. Subjects are given up to two chances to complete each item. Assistive devices are permitted for tasks 6 – 9.

Equipment:

- Pen/paper
- Kidney beans/bowl
- Empty coffee can
- Teaspoon
- Heavy book
- Book table
- Shelf
- Jacket/cardigan sweater or lab coat
- Penny
- Stairs

Task 1

- Ask the subject, when given the command to "go" to write the sentence "whales live in the blue ocean." Time from the word "go" until the pen is lifted from the page at the end of the sentence. All words must be included and legible. Period need not be included for task to be considered completed.

Task 2

- Five kidney beans are placed in a bowl, 5 inches from the edge of the desk in front of the patient. An empty coffee can is placed on the table at the patient's non-dominant side. A teaspoon is place in the patient's dominant hand. Ask the subject on the command "go" to pick up the beans, one at a time and place each in the coffee can. Time from the command "go" until the last bean is heard hitting the bottom of the can.

Physical Performance Test (continued)

Task 3

- Place a Physician's Desk Reference or other heavy book on a table in front of the patient. Ask the patient, when given the command "go" to place the book on a shelf above shoulder level. Time from the command "go" to the time the book is resting on the shelf.

Task 4

- If the subject has a jacket cardigan sweater, ask them to remove it. If not, give the subject a lab coat. Ask the subject, on the command "go" to put the coat on completely such that it is straight on their shoulders and then remove the garment completely. Time from the command "go" until the garment has been complexly removed.

Task 5

- Place a penny approximately1 foot from the patient's foot on the dominant side. Ask the patient, on the command "go" to pick up the penny from the floor and stand up. Time from the command "go" until the subject is standing erect with a penny in hand.

Task 6

- With subject in a corridor or in and open room, ask the subject to turn 360 degrees. Evaluate using the scale on PPT scoring sheet.

Task 7

- Bring subject to start on a 50 –foot walk test course (25 feet out and 25 feet back) and ask the subject, on the command "go" to walk to the 25-foot mark and back. Time from the command "go" until the starting line is crossed on the way back.

Task 8

- Bring subject to foot of stairs (nine to 12 steps) and ask subject, on the command" go" to begin climbing stairs until they feel tired and wishes to stop. Before beginning this task, alert the subject to the possibility of developing chest pain or shortness of breath and inform the subject to tell you if any of these symptoms occur. Escort the subject up the stairs. Time from the command "go" until the subjects' first foot reaches the top of the first flight of stairs. Record the number of flights (maximum is four) completed (up and down is one flight).

Physical Performance Test (continued)

Table 8 Physical Performance Test Scores- means, standard deviations, and confidence intervals by age, gender, and use of assistive device

Age	Group	N	Mean	SD	CI
60-69	Male	1	26.0	----	17.9-34.1
	Female	5	26.4	0.9	22.8-30.0
	Overall	6	26.3	0.8	25.5-27.2
70-79	Male	9	24.6	1.7	21.9-27.2
	Female	10	25.1	0.9	22.5-27.7
	Overall	19	24.8	1.3	24.2-25.5
80-89	Male	10	20.4	4.8	17.8-23.0
	Female	24	19.5	3.8	17.9-21.2
	No Device	24	21.3	3.2	19.9-22.7
	Device	10	16.1	3.6	13.9-18.3
	Overall	34	19.8	4.1	18.4-21.2
90-101	Male	2	16.5	6.4	10.8-22.2
	Female	15	16.2	6.0	14.1-18.3
	No Device	7	18.9	6.4	16.2-21.5
	Device	10	14.4	4.8	12.2-16.6
	Overall	17	16.2	5.8	1.3-19.2

Physical Performance Test (continued)

Scoring Sheet

No.	Task	Measurement	Time	Scoring	Score
1.	Write a Sentence (whales live in the blue ocean.)	seconds		≤ 10 sec = 4 10.5-15 sec = 3 15.5 – 20 sec = 2 >20 sec = 1 unable = 0	
2.	Simulated eating	seconds		≤ 10 sec = 4 10.5-15 sec = 3 15.5 – 20 sec = 2 >20 sec = 1 unable = 0	
3.	Lift a book and put it on a shelf Book PDR 1988: 5.5 lbs Bed height 59 cm Shelf height 118 cm All sitting with feet on floor	seconds		≤ 2 sec = 4 2.5- 4 sec = 3 4.5 – 6 sec = 2 > 6 sec = 1 unable = 0	
4.	Put on and remove a jacket 1. Standing 2. Use of bathrobe; button down shirt; hospital gown.	Seconds		≤ 10 sec = 4 10.5-15 sec = 3 15.5 – 20 sec = 2 >20 sec = 1 unable = 0	
5.	Pick up a penny from floor	Seconds		≤ 2 sec = 4 2.5- 4 sec = 3 4.5 – 6 sec = 2 > 6 sec = 1 unable = 0	
6.	Turn 360 degrees			Discontinuous steps =0 Continuous steps = 2 Unsteady =0 Steady= 2	

Physical Performance Test (continued)

Scoring Sheet (continued)

No.	Task	Measurement	Time	Scoring	Score
7.	50 foot walk test starting sitting for instructions	seconds		≤ 15 sec = 4 15.5- 20 sec = 3 20.5 – 25 sec = 2 >25 sec = 1 unable = 0	
8.	Climb one flight of stairs	seconds		≤ 5 sec = 4 5.5- 10 sec = 3 10.5 – 15 sec = 2 >15 sec = 1 unable = 0	
9.	Climb stairs			Number of flights of stairs up and down (maximum of 4)	
	Total score (maximum 36 for 9 items; 28 for 7 items)				
	Round time measurements to nearest 0.5 seconds.				Total score

References

Lusardi, M.M. (2004). Functional Performance in Community Living Older Adults. Journal of Geriatric Physical Therapy, 26(3), 14-22.

Reuben DB, Siu AL. An Objective Measure of Physical Function of Elderly Outpatients (The Physical Performance Test). Journal of The American Geriatric Society 1990; 38 (10):1105-1112.

Standardized Test Compendium

Postural Assessment Scale for Stroke

(PASS)

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Postural Assessment Scale for Stroke (PASS)

Purpose

The PASS is a 12-item performance-based scale used for assessing and monitoring postural control following stroke.

Equipment Required

- 50cm-high examination table (e.g. Bobath plane)
- Stop watch
- Pen

General Information

- The scale comprises of 12 items with increasing difficulty which measure balance in lying, sitting and standing.
- It is specially designed for individuals with stroke regardless of their postural competence.
- It is especially sensitive for assessment of postural control in the first 3 months and can discriminate between right and left-brain damage in individuals with stroke.
- It measures the ability of an individual with stroke to maintain stable postures and equilibrium during positional changes.
- It consists of a 4-point scale where the items are scored from 0 to 3, and the total scoring ranges from 0 to 36.
- Give the subject instructions for each of the 12 items.
- When scoring the item, record the lowest response category that applies for each item.

Maintaining a Posture (5 Items)

- Sitting Without Support
- Standing with Support
- Standing Without Support
- Standing on Nonparetic Leg
- Standing on Paretic Leg

Changing a Posture (7 Items)

- Supine to Paretic Side Lateral
- Supine to Nonparetic Side Lateral
- Supine to Sitting Up on the Edge of the Mat
- Sitting on the Edge of the Mat to Supine
- Sitting to Standing Up
- Standing Up to Sitting Down
- Standing, Picking Up a Pencil from the Floor

Postural Assessment Scale for Stroke (PASS) (continued)

References

Heart & Stroke Foundation, Canadian Partnership for Stroke Recovery. Postural Assessment Scale for Stroke Patients (PASS). http://www.strokengine.ca/assess/pass/ (accessed 28 mars 2017)

Benaim C, Pérennou DA, Villy J, Rousseaux M, Pelissier JY. Validation of a standardized assessment of postural control in stroke patients: the Postural Assessment Scale for Stroke Patients (PASS). Stroke. 1999 Sep; 30:1862-8.

Mao HF, Hsueh IP, Tang PF, Sheu CF, Hsieh CL. Analysis and comparison of the psychometric properties of three balance measures for stroke patients. Stroke 2002; 33: 1022-7

Poole JL, Whitney SL. Motor assessment scale for stroke patient's concurrent validity and interrater reliability. Arch Phys Med Rehabil. 1988; 69:195–197.

Wang CH, Hsueh IP, Sheu CF, Yao G, Hsieh CL. Psychometric properties of 2 simplified 3-level balance scales used for patients with stroke. Phys Ther 2004;84(5):430-8.

Standardized Test Compendium

Timed 10 Meter Walk Test

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Timed 10 Meter Walk Test

Purpose

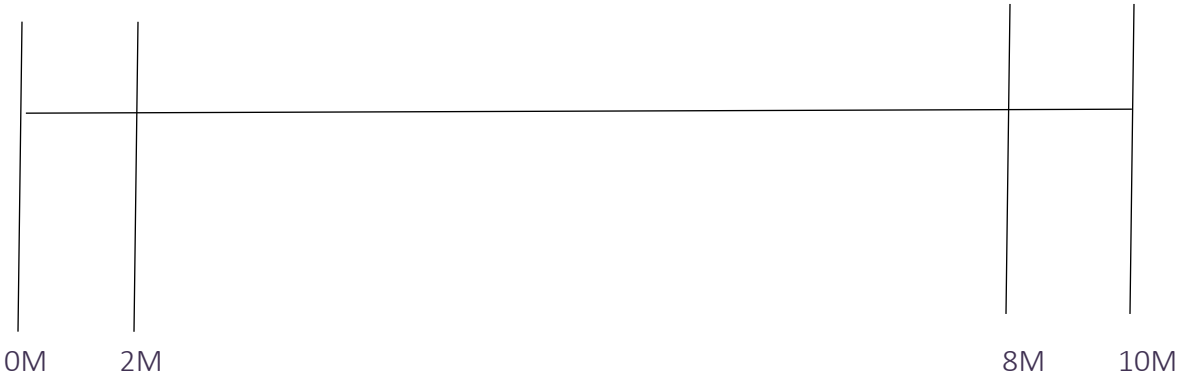
To assess walking speed in meters per second over a short distance. It can be employed to determine functional mobility, gait, and vestibular function.

Equipment

- Stopwatch
- tape
- clear pathway

Setup

Measure and mark 10-meter walkway
Add a mark at 2-meters
Add a mark at 8-meters



Instructions

1. The individual walks without assistance for 10 meters, with the time measured for the intermediate 6 meters to allow for acceleration and deceleration
2. Assistive devices may be used, but must be kept consistent and documented for each test
3. Start timing when the toes pass the 2-meter mark
4. Stop timing when the toes pass the 8-meter mark
5. Can be tested at either preferred walking speed or maximum walking speed (ensure to document which was tested)

Timed 10 Meter Walk Test (continued)

6. Normal comfortable speed: "I will say ready, set, go. When I say go, walk at your normal comfortable speed until I say stop"
   Maximum speed trials: "I will say ready, set, go. When I say go, walk as fast as you safely can until I say stop"
7. Perform three trials and calculate the average of three trials.

Calculate Speed:

Total time is recorded in seconds (to the nearest tenth) and the self-selected walking speed in meters per second is calculated to the nearest tenth using the formula:
6meters (19th, 8in) / _____seconds → _____m/sec gait speed

PPME Crosswalk:

Time to walk 6 meters	PPME Score	Correlation to fall risk
≥ 13 seconds	1	High risk of falls and decline (i.e. much < 1.0 m/sec)
≥ 6 but < 13 seconds	2	Moderate risk of falls and decline (i.e. < 1.0 m/sec)
< 6 seconds	2	Normal function, low risk of decline and falls (i.e. > 1.0 m/sec)

References

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Bohannon RW, Andrews AW, Thomas MW. Walking speed: reference values and correlates for older adults. J Orthop Sports Phys Ther. 1996;24(2):86-90

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TUG

Timed Up and Go

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TUG- Timed Up and Go

Purpose

- To assess mobility, balance, walking ability, and fall risk in older adults.

Diagnosis/Conditions

- Arthritis + Joint Conditions, Cerebral Palsy, Multiple Sclerosis, Parkinson's Disease, Neurological Conditions, Spinal Cord Injury, Stroke Recovery, Vestibular Disorders

Equipment

- Stop watch
- Standard arm chair
- Masking tape

General Information

- The patient should sit on a standard armchair, placing his/her back against the chair and resting his/her arms on the chair's arm rests.
- Any assistive device used for walking should be nearby.
- Regular footwear and customary walking aids should be used.
- The patient should walk to a line that is 3 meters (9.8 feet) away, turn around at the line, walk back to the chair, and sit down.
- The test ends when the patient's buttocks touch the seat.
- Patient should be instructed to use a comfortable and safe walking speed.
- A stopwatch should be used to time the test in seconds.
- Therapist should always stay by the patient for safety.

Set-Up

- Measure and mark with tape a 3-meter (9.8 feet) walkway
- Place a standard height chair (seat height 46cm, arm height 67 cm) at the beginning of the walkway.

Instructions

- Instruct the patient to sit on the chair and place his/her back against the chair and rest his/her arms on the chair's arms.
- The upper extremities should not be on the assistive device (if used for walking), but it should be nearby.
- Demonstrate the test to the patient.
- When the patient is ready, say "Go"
- The stopwatch should start when you say go, and should be stopped when the patient's buttocks touch the seat.

TUG- Timed Up and Go (continued)

References

Podsiadlo, D. and Richardson, S. (1991). “The timed “Up & Go”. A test of basic functional mobility for frail elderly persons.” J Am Geriatr Soc 39(2): 142-148

Standardized Test Compendium

Tinetti Balance Assessment Tool

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Tinetti Balance Assessment Tool

Purpose

To measures an older adult's gait and balance abilities. Designed to measure balance (including fall risk) and gait function in elderly, but has also been used for patients with various other conditions.

Diagnosis/Conditions

Parkinson's Disease, Stroke Recovery and other Neurologic Conditions

Equipment

- Tinetti Balance Assessment Form
- Chair
-

General Information

- Time to complete 10 to 15 minutes including scoring.
- Scoring of the Tinetti Assessment Tool is done on a three-point Ordinal scale with a range of 0-2. A score of 0 represents the most impairment, while a 2 would represent independence of the patient. The individual scores are then combined to form three measures; an overall gait assessment score, an overall balance assessment score, and a gait and balance score.

Scoring Interpretation

- The maximum score for the gait component is 12 points.
- The maximum score for the balance component is 16 points.
- The maximum total score is 28 points.
- In general, patients who score below 19 are at a high risk for falls.
- Patients who score in the range of 19-24 indicate that the patient has a risk for falls.

Tinetti Balance Assessment Tool (continued)

Instructions

Refer to Tinetti Balance Assessment Form

- Balance Tests
  - Sitting Balance
  - Arising from Chair
  - Attempts to Rise
  - Immediate Standing Balance
  - Standing Balance
  - Sternal Nudge
  - Eyes Closed
  - Turning 360 Degrees
  - Sitting Down

- Gait Tests (subject walks at a normal pace)
  - Initiation of Gait
  - Step Length
  - Step Height (Foot Clearance)
  - Step Symmetry
  - Step Continuity
  - Path
  - Trunk
  - Walking Stance
  - Assistive Advice Used

References

Lewis C. Balance, Gait Test Proves Simple Yet useful. P.T. Bulletin 1993; 2110:9 & 40

Tinetti ME. Performance-Oriented Assessment of Mobility Problems in Elderly_Patients.JAGS 1986 34:119-126.

Tinetti Balance Assessment Tool (continued)

Patient Name_____

Patient ID_____ Site of Service:_____

Balance Section

Patient is seated in hard, armless chair

		Date				
Sitting Balance	Leans or slides in chair Steady, safe	=0 =1				
Rises from Chair	Unable to without help Able, uses arms to help Able without use of arms	=0 =1 =2				
Attempts to Rise	Unable to without help Able, requires >1 attempt Able to rise, 1 attempt	=0 =1 =2				
Immediate Standing Balance (first 5 seconds)	Unsteady (staggers, sways) Steady but uses walker or other support Steady without walker or other support	=0 =1 =2				
Standing Balance	Unsteady Steady but wide stance and uses cane or other support Narrow stance without support	=0 =1 =2				
Nudged (patient at max position with feet as lose together as possible.	Begins to fall Staggers, grabs, catches self Steady	=0 =1 =2				
Eyes Closed (patient at max positions, see previous test)	Unsteady Steady	=0 =1				
Turning 360 Degrees	Discontinues steps Continues steps	=0 =1				
	Unsteady Steady	=0 =1				
Sitting Down	Unsafe (misjudges distance, falls into chair) Uses arms or not a smooth motion Safe, smooth motion	=0 =1 =2				
	Balance Score		/16	/16	/16	/16

Tinetti Balance Assessment Tool (continued)

Gait Section

Patient stands with examiner, walks down hallway or across room, fist at "usual" pace, then back at "rapid but safe" pace (using usual walking aids).

		Date				
Indication of gait (immediately told to "go")	Any hesitancy, or multiple attempts No hesitancy	=0 =1				
Step Length and Height	Right Swing foot: Does not pass left stance foot with step Passes left stance foot Right foot does not clear floor completely with step Right foot completely clears floor	 =0 =1 =0 =1				
	Left Swing foot: Does not pass right stance foot with step Passes right stance foot Left foot does not clear floor completely with step Left foot completely clears floor	 =0 =1 =0 =1				
Step Symmetry	Right and left step length not equal (estimate) Right and left step length appear equal	=0 =1				
Step Continuity	Stopping or discontinuity between steps Steps appear continuous	=0 =1				
Path (estimated in relation to floor tiles, observe excursion of 1 foot over 10 feet of the course)	Marked deviation Mild/moderate deviation or uses walking aid Straight without walking aid	=0 =1 =2				
Trunk	Marked sway or uses walking aid No sway but flex knees or back or spread arms out while walking No sway, no flexion, not aids	=0 =1 =2				
Walking Time	Hells apart Health almost touching while walking	=0 =1				
	Gait Score		/12	/12	/12	/12
	Balance Score Carried Forward		/16	/16	/16	/16
	Totals Score= Balance + Gait		/28	/28	/28	/28

Standardized Test Compendium

Trunk Control Test

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Trunk Control Test

Purpose

To measure four simple aspects of trunk movement.

Description

The four aspects of the trunk test are rolling to weak side, rolling to strong side, balance in sitting position, and sit up from lying down.

Equipment

- Bed or treatment table

Scoring

- Total Score Range: 0 (minimum) to 100(maximum, indicating better performance).
- Score each item, 0, 12, or 25.
    - 0= unable to perform movement without assistance
    - 12= able to perform movement, but in an abnormal style
    - 25= able to complete movement normally
- For the sitting balance item, a patient scores 12 if they need to touch anything with their hands to stay upright, and 0 if they are unable to stay up (by any means) for 30 seconds.