SPIRiTT UIN: Group: Participant's name: DOB:

UNIVERSITY OF SURREY

MULTIDISCIPLINARY TEAM CONTRIBUTIONS

No.	Name (please print)	Signature	Initials	Position	Date	Time of arrival	Time of leaving	Participant Consent (initials)

CURRENT MAIN PROBLEMS

No.	Description of main problems

REFERRALS MADE

Service	Reason	By whom

RECOMMENDATIONS AND CHANGES

Recommendation for changes to medication	Reason	By whom	Imple-mented?	Aids/adaptations			Who paid?	Amount (£)
				Recommendations	By whom	Obtained?		

GENERAL INFORMATION

Title:		Surname:		Forenames:		Preferred name:	
Date of birth:		Gender:		Ethnic origin:		Language:	
Address:							
Telephone (home):				Work:		Mobile:	
GP DETAILS							
GP Name:				Practice Name:			
Practice address:							
Telephone:							
SOCIAL ASSESSMENT							
House:	Detached	Semi-detached	Terraced	Bungalow	Upstairs flat	Sheltered housing	
Steps inside:	Yes/No	Steps outside:	Yes/No	Stair lift:	Yes No		
Bathroom:	Upstairs Downstairs	Toilet:	Upstairs Downstairs	Pets:	Yes No		
Lives:		Comments:					
Support from family/carer:				Main Carer's Name:			
Carer's address:	As above						
Telephone:	As above						
Next of kin:	Same as Main Carer						
Next of kin's address:							
Telephone:							

SERVICES								
Services and Support	M	T	W	T	F	S	S	Comments
Home care (personal)								
Home care (domestic)								
Meals on wheels								
Day centre								
District nurse								
Community psychiatric nurse								
Other (state):								

Driving:	Yes No	DVLA aware:	Yes No

MEDICAL HISTORY			
Date of diagnosis:		Diagnosis made by:	Consultant GP
Date of noticing symptoms:		Duration of condition:	
Falls:	Never	Occasionally (1-2 a month)	Frequently (weekly basis or more)
Explanation for falls if able:			
Other medical/health problems:			

SPIRiTT UIN: Group: Participant's name: DOB:

MDS-UPDRS SCORE SHEET

Assessment Date:		Investigator ID:		Consent given:	
PART I: Non-Motor Aspects of Experiences of Daily Living *(completed by health care professional)*					
1A: Source of information: Patient Caregiver Patient and Caregiver					
1.1 Cognitive impairment			1.4 Anxious mood		
1.2 Hallucinations and psychosis			1.5 Apathy		
1.3 Depressed mood			1.6 Features of Dopamine Dysregulation Syndrome		
PARTS I & II: PATIENT QUESTIONNAIRE *(completed by patient in advance of first visit)*					
1.6a: Source of information: Patient Caregiver Patient and Caregiver					
1.7 Sleep problems			2.4 Eating tasks		
1.8 Daytime sleepiness			2.5 Dressing		
1.9 Pain and other sensations			2.6 Hygiene		
1.10 Urinary problems			2.7 Handwriting		
1.11 Constipation problems			2.8 Doing hobbies and other activities		
1.12 Light headedness on standing			2.9 Turning in bed		
1.13 Fatigue			2.10 Tremor		
2.1 Speech			2.11 Getting out of bed, a car or a deep chair		
2.2 Saliva and drooling			2.12 Walking and balance		
2.3 Chewing and swallowing			2.13 Freezing		
PART III: Motor Examination *(completed by health care professional)*					
3a Is the participant on medication?			3.9 Arising from chair		
3b Participant's clinical state			3.10 Gait		
3c Is the participant on Levodopa?			3.11 Freezing of gait		
3c1 If yes, minutes since last dose:			3.12 Postural stability		
3.1 Speech			3.13 Posture		
3.2 Facial expression			3.14 Global spontaneity of movement		
3.3b Rigidity – RUE			3.15a Postural tremor – RH		
3.3c Rigidity – LUE			3.15b Postural tremor – LH		
3.3d Rigidity – RLE			3.16a Kinetic tremor – RH		
3.3e Rigidity – LLE			3.16b Kinetic tremor – LH		
3.4a Finger tapping – RH			3.17a Rest tremor amplitude – RUE		
3.4b Finger tapping – LH			3.17b Rest tremor amplitude – LUE		
3.5a Hand movements – RH			3.17c Rest tremor amplitude – RLE		
3.5b Hand movements – LH			3.17d Rest tremor amplitude – LLE		
3.6a Pronation-supination movements – RH			3.17e Rest tremor amplitude – Lip/jaw		
3.6b Pronation-supination movements – LH			3.18 Constancy of rest		
3.7a Toe tapping – RF			Were dyskinesias present?		
3.7b Toe tapping – LF			Did these movements interfere with ratings?		
3.8a Leg agility – RL			Hoehn and Yahr Stage		
3.8b Leg agility – LL					
PART IV: Motor Complications *(completed by health care professional)*					
4.1 Time spent with dyskinesias			4.4 Functional impact of fluctuations		
4.2 Functional impact of dyskinesias			4.5 Complexity of motor fluctuations		
4.3 Time spent in OFF state			4.6 Painful OFF-state dystonia		

LIFE PSYCHOL TOOL *(completed by participant in advance)*

To what level does Parkinson's affect:				
Anger and frustration	Not affected	Mildly affected	Moderately affected	Severely affected
Mood (anxiety and depression)	Not affected	Mildly affected	Moderately affected	Severely affected
Fatigue/energy levels	Not affected	Mildly affected	Moderately affected	Severely affected
Sleep	Not affected	Mildly affected	Moderately affected	Severely affected
Pain	Not affected	Mildly affected	Moderately affected	Severely affected
Mobility and/or physical function	Not affected	Mildly affected	Moderately affected	Severely affected
Finances	Not affected	Mildly affected	Moderately affected	Severely affected
Independence	Not affected	Mildly affected	Moderately affected	Severely affected
Domestic task	Not affected	Mildly affected	Moderately affected	Severely affected
Social life and hobbies	Not affected	Mildly affected	Moderately affected	Severely affected

SPIRiTT UIN: **Group:** **Participant's name:** **DOB:**

PARKINSON'S NURSE ASSESSMENT

Date:		Consent given:	

Subjective main problems:

OBSERVATIONS

Blood pressure:	Lying:		Standing:	

Symptomatic postural hypotension:	Yes No	Pulse:	

ANTI-PARKINSON'S DRUG CHART

Drug	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23

Summary of assessment

Leaflets/advice given:			
Plan for interventions/advice:			
Referrals:			
Additional comments:			
Completed by:		Designation:	

Signature:		Date:	

NON-MOTOR SYMPTOMS			
SYMPTOMS	**PRESENT**	**ABSENT**	**COMMENTS**
Problems with drooling			
Problems with swallowing			
Bowel problems (constipation)			
Bladder problems (incontinence)			
Sexual and relationship problems			
Pain			
Apathy			
Fatigue			
Depression			
Hallucinations			
Anxiety			
Dizziness			
Sleep problems			
SIDE EFFECTS OF MEDICATION			
SIDE EFFECT	**PRESENT**	**ABSENT**	**COMMENTS**
Dyskinesia			
On/off fluctuations			
End of dose "wearing off"			
Nausea			

Completed by:		**Designation:**	
Signature:		**Date:**	

PHYSIOTHERAPY ASSESSMENT

Date:		Consent given:	
Subjective main problem:			
Previous PT? Yes No	Description:		
Falls?	Never	Occasionally (1-2 a month)	Frequently (weekly basis or more)
Explanation of falls (if appropriate and able):			
Freezing?		ON/OFF?	

OBSERVATIONS				
Posture in standing				
Hips/knees:				
Spine:				
Head position:				
Daily activities				
Getting into bed:				
Getting out of bed:				
Turning over in bed:				
Sitting to standing:				
Turning 180°:	4-6 steps	7-8 steps	9-10 steps	11 or more steps
Stairs:				
Other physical difficulties:				

Gait			
Mobility indoors:			
Mobility outdoors:			
Arm swing:			
Size of step:			
Heel strike:	Heel/toe	Flat footed	Toe/heel
Any other relevant information:			
Plan for interventions/advice:			

Completed by:		**Designation:**	
Signature:		**Date:**	

If during the initial assessment, there were problems with poor posture, transfers including bed mobility, balance and falls, mobility including freezing and turning, then a further in depth assessment would follow which could include as appropriate Lindop Parkinson's Assessment Scale and Berg Balance 7 item short form version. A patient specific treatment programme would be provided and may include as appropriate, the Yale balance sheet exercise (level 1-5), Roche exercises for patients with Parkinson's and handwritten individually tailored exercises.

LINDOP PARKINSON'S ASSESSMENT SCALE

Date:		Consent given:	
Time of last medication:		Walking aid:	

Gait mobility						
			3=	2=	1=	0=
Score =		Sit to stand:	Unaided with ease	Unaided with effort	Help of 1	Help of +2
Score =		Timed unsupported stand:	60+ seconds	49-59 seconds	30-44 seconds	0-29 seconds
Score =		Timed up & go:	10-20 seconds	21-35 seconds	36-60 seconds	60+ seconds
Score =		180 turn to right:	4-6 steps	7-8 steps	9-10 steps	11+ steps
Score =		180 turn to left:	4-6 steps	7-8 steps	9-10 steps	11+ steps
Score =		Walking through doorway:	No freeze/festination	Some festination	Freezes once	Freezes 2+ times
Total =						

Bed mobility						
			3=	2=	1=	0=
Score =		Sit to lie (56cm bed):	Unaided with ease (≤5 seconds)	Unaided with effort (6+ seconds)	Help of 1	Help of 2/unable
Score =		Turn to left on bed:	Unaided with ease (≤5 seconds)	Unaided with effort (6+ seconds)	Help of 1	Help of 2/unable
Score =		Turn to right on bed:	Unaided with ease (≤5 seconds)	Unaided with effort (6+ seconds)	Help of 1	Help of 2/unable
Score =		Lie to sit on bed:	Unaided with ease (≤5 seconds)	Unaided with effort (6+ seconds)	Help of 1	Help of 2/unable
Total =						

BERG BALANCE 7 ITEM SHORT FORM VERSION

1. Sitting to standing Instructions: *Please stand up. Try not to use your hands for support.*		
(4) Able to stand without using hands and stabilise independently	(3) Able to stand independently using hands	
(2) Able to stand using hands after several tries	(1) Needs minimal aid to stand or to stabilise	
(0) Needs moderate or maximal assist to stand		Score =
2. Standing unsupported with eyes closed Instructions: *Please close your eyes and stand still for 10 seconds.*		
(4) Able to stand 10 seconds safely	(3) Able to stand 10 seconds with supervision	
(2) Able to stand 3 seconds	(1) Unable to keep eyes closed 3 seconds but stays steady	
(0) Needs help to keep from falling		Score =
3. Reaching forward with outstretched arm while standing Instructions: *Lift arm to 90 degrees. Stretch out your fingers and reach forward as far as you can. (Examiner places a ruler at end of fingertips when arm is at 90 degrees. Fingers should not touch the ruler while reaching forward. The recorded measure is the distance forward that the finger reaches while the subject is in the most forward lean position. When possible, ask subject to use both arms when reaching to avoid rotation of the trunk.)*		
(4) Can reach forward confidently >25cm (10 inches)	(3) Can reach forward >12cm safely (5 inches)	
(2) Can reach forward >5cm safely (2 inches)	(1) Reaches forward but needs supervision	
(0) Loses balance while trying/requires external support		Score =

4. Pick up object from the floor from a standing position Instructions: *Pick up the shoe/slipper which is placed in front of your feet*		
(4) Able to pick up slipper safely and easily	(3) Able to pick up slipper but needs supervision	
(2) Unable to pick up but reaches 2-5cm (1-2 inches) from slipper and keeps balance independently	(1) Unable to pick up and needs supervision while trying	
(0) Unable to try/needs assist to keep from losing balance or falling		Score =
5. Turning to look behind over left and right shoulders while standing Instructions: *Turn to look directly behind you over toward left shoulder. Repeat to the right. Examiner may pick up an object to look at directly behind the subject to encourage better arm twist*		
(4) Looks behind from both sides and weight shifts well	(3) Looks behind one side only other side shows less weight shift	
(2) Turns sideways only but maintains balance	(1) Needs supervision when turning	
(0) Needs assist to keep from losing balance or falling		Score =
6. Standing unsupported one foot in front Instructions: *(Demonstrate to participant) 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. (To score 3 points, the length of the step should exceed the length of the other foot and the width of the stance should approximate the subject's normal stride width)*		
(4) Able to place foot tandem independently and hold 30 seconds	(3) Able to place foot ahead of other independently and hold 30 seconds	
(2) Able to take small step independently and hold 30 seconds	(1) Needs help to step but can hold 15 seconds	
(0) Loses balance while stepping or standing		Score =
7. Standing on one leg Instructions: *Stand on one leg as long as you can without holding*		
(4) Able to lift leg independently and hold >10 seconds	(3) Able to lift leg independently and hold 5-10 seconds	
(2) Able to lift leg independently and hold ≥ 3 seconds	(1) Tries to lift leg unable to hold 3 seconds but remains Standing independently	
(0) Unable to try or needs assist to prevent fall		Score =
	Total score (Maximum = 28) = ***[Score < 23 is considered at risk for falling]***	

Additional comments:

Completed by:		**Designation:**	
Signature:		**Date:**	

SPIRiTT UIN: **Group:** **Participant's name:** **DOB:**

OCCUPATIONAL THERAPY ASSESSMENT

Date:		**Consent given:**	
Subjective main problem:			
Previous OT? Yes No	**Description:**		

	Independent	Independent with equipment	Needs assistance	Unable	Comments
Falls/ mobility					
Stairs/steps					
Handwriting					
Confusion					
Memory loss					
Housework					
Cooking					
Laundry					
Shopping					
Dressing					
Washing					
Bathing					
Toilet					
Hair					

SPIRiTT UIN: Group: Participant's name: DOB:

	Independent	Independent with equipment	Needs assistance	Unable	Comments
Shaving					
Bed					
Chair					
Communications					
Eating					
Driving					
In/out car					
Gardening					
Read/hold book /paper					
Other hobbies					

Known to Social Services:	Yes No

Any other relevant information:

Leaflets/advice given:

Plan for interventions/advice:

Completed by:		**Designation:**	
Signature:		**Date:**	

SPEECH AND LANGUAGE THERAPY ASSESSMENT

Date:		Consent given:	
Subjective main problem:			
SLT Observations:			
Previous SLT? Yes No	**Description:**		

Do you ever do any practice exercises to improve your speech?	Yes No
If yes, how much time do you spend a day or week?	
1) Maximum sustained phonation ***"Say 'ahhh' for as loud and as long as you can"*** …………………………… **seconds** ……………………………………… **db**	15-25 Normal 11-24 Good 6-10 Fair 1-5 Poor
2) Ability to sustain /s/ on exhalation ***"Let your breath out on a hiss 'sssss'. Keep the sound going for as long as you can"*** …………………………… **seconds**	20-30 Normal 15-19 Good 10-14 Fair 1-9 Poor
3) Ability to crescendo on /ah/ ***"As you let your breath out on an 'ahhh', begin softly and gradually make the sound louder and louder"***	Good ability Some variation Poor Unable to vary volume
4) Maximum db – Functional phrase ***"Please read aloud from the card as if you were speaking to someone sitting opposite"***	……………………………………… **db**
DIADOCHOKINESIS	
5) Open and close mouth (5 seconds) …………………………… **repetitions**	15-20 Normal 10-14 Good 5-9 Fair 1-4 Poor
6) Tongue in and out (5 seconds) …………………………… **repetitions**	18-25 Normal 14-17 Good 8-13 Fair 1-7 Poor
7) "Oo-ee" (5 seconds) …………………………… **repetitions**	15-20 Normal 10-14 Good 5-9 Fair 1-4 Poor

8) "Pa-pa-pa" (5 seconds) **................................ repetitions**	20-30 Normal 15-19 Good 8-14 Fair 1-7 Poor
9) "Ta-ta-ta" (5 seconds) **................................ repetitions**	20-30 Normal 15-19 Good 8-14 Fair 1-7 Poor
10) "Ka-ka-ka" (5 seconds) **................................ repetitions**	20-30 Normal 15-19 Good 8-14 Fair 1-7 Poor
11) "P-T-K" (5 seconds) **................................ repetitions**	20-30 Normal 15-19 Good 8-14 Fair 1-7 Poor
Overall, if any, what impact do you feel your speech difficulty is having on your life? **Score ....**	1 Only occasionally (e.g. in company) 2 Moderate (more than once/week) 3 Significant trouble (every day)
Do you feel that you understand why you have speech difficulty and what you can do to improve your speech?	Yes No
Have you had any problems with eating or drinking?	Yes No
If yes, please describe and complete dysphagia assessment and Sydney Swallow Questionnaire	
How often do you experience swallowing problems? **Score ....**	1 Mild (once a week) 2 Moderate (more than once/week) 3 Severe (every day)
How much does your swallowing problem interfere with your enjoyment or quality of life? **Score ....**	1 Only occasionally (e.g. in company) 2 Moderate (more than once/week) 3 Significant trouble (every day)
What strategies have you used that facilitate your eating/drinking?	
How long does it take you to eat an average meal?	Less than 15 minutes 15-30 minutes 30-45 minutes 45-60 minutes more than 60 minutes Unable to swallow at all
Have you modified what you eat/drink to make it easier?	Yes No
If yes, please describe	

SPIRiTT UIN: **Group:** **Participant's name:** **DOB:**

Current eating/drinking

☐ **Fluids**	☐ **Normal**	☐ **Thickened (specify stage)..............................**
☐ **Food**	☐ **Normal**	☐ **Modified (specify)..**

Do you have any difficulty swallowing your saliva?	Yes No
If yes, please describe	
Have you had any recent chest infections?	Yes No
If yes, please explain	

Oral hygiene (please check all that apply)

☐ **Clean** ☐ **Dentures** ☐ **Dehydrated** ☐ **Excess secretions** ☐ **Coated**

SYDNEY SWALLOW QUESTIONNAIRE

PLEASE PLACE AN X ON THE LINE TO INDICATE HOW SEVERE YOUR SWALLOWING PROBLEM IS FOR EACH QUESTION BELOW

1) How much difficulty do you have swallowing at present?

No difficulty at all |————————————| **Unable to swallow at all**

2) How much difficulty do you have swallowing THIN liquids (e.g. tea, soft drink, beer, coffee)?

No difficulty at all |————————————| **Unable to swallow at all**

3) How much difficulty do you have swallowing THICK liquids (e.g. milkshake, soup, custard)?

No difficulty at all |————————————| **Unable to swallow at all**

4) How much difficulty do you have swallowing SOFT foods (e.g. scrambled egg, mashed potato)?

No difficulty at all |————————————| **Unable to swallow at all**

5) How much difficulty do you have swallowing HARD foods (e.g. steak, raw vegetables, raw fruit)?

No difficulty at all |————————————| **Unable to swallow at all**

6) How much difficulty do you have swallowing DRY foods (e.g. bread, biscuits, nuts)?

No difficulty at all |————————————| **Unable to swallow at all**

7) Do you have any difficulty swallowing your saliva?		
No difficulty at all	├──────────┤	Unable to swallow at all
8) Do you have any difficulty starting a swallow?		
Never occurs	├──────────┤	Occurs every time I swallow
9) Do you ever have a feeling of food getting stuck in your throat when you swallow?		
Never occurs	├──────────┤	Occurs every time I swallow
10) Do you ever cough or choke when swallowing solid foods (e.g. bread, meat, fruit)?		
Never occurs	├──────────┤	Occurs every time I eat
11) Do you ever cough or choke when swallowing liquids (e.g. coffee, tea, water, beer)?		
Never occurs	├──────────┤	Occurs every time I drink
13) When you swallow, does food or liquid go up behind your nose or come out of your nose?		
Never occurs	├──────────┤	Occurs every time I swallow
14) Do you ever need to swallow more than once for your food to go down?		
Never occurs	├──────────┤	Occurs every time I swallow
15) Do you ever cough up or spit out food or liquids DURING a meal?		
Never occurs	├──────────┤	Occurs every time I eat or drink
16) How do you rate the severity of your swallowing problem today?		
No problem	├──────────┤	Extremely severe problem
17) How much does your swallowing problem interfere with your enjoyment or quality of life?		
No interference	├──────────┤	Extreme interference

OROFACIAL EXAMINATION				
Cranial nerve	**Action**	**WNL**	**Impaired**	**Comments**
V	Open jaw			
	Close jaw			
	Lateral movement			
VII	Lip protrusion/retraction			
	Alternate			
	Symmetry of smile			
	Lip seal (puff air into cheeks)			
IX	Altered taste			
XII	Tongue protrusion/retraction			
	Elevation			
	Depression			
	Lateral L/R			
	Into cheek L/R			
	Around lips			
X	Palate elevation/depression			
	Voluntary cough			
	Reflexive cough			
	Voice quality and pitch			
Observation of liquid swallow				

SLT summary of communication and swallowing			
Plan for interventions/advice:			
Leaflets/advice given: (*Tips information leaflet – minimum*)			
Completed by:		**Designation:**	
Signature:		**Date:**	

SPIRiTT UIN: **Group:** **Participant's name:** **DOB:**

AGREED CARE PLAN

No.	Date	Problem	Action	Goal	Review	Review date	Signature

SPIRiTT UIN: Group: Participant's name: DOB:

MULTIDISCIPLINARY NOTES

DATE	NOTES	SIGNATURE (POSITION)