



PHYSICAL THERAPY	Score	Interpretation
Timed Up and Go (TUG): This tests the patient's mobility and fall risk. It is administered by having the patient stand from a chair, walk 3 meters (10 feet), turn around, walk back to the chair and sit.	< 10 seconds	Low fall risk; patient is freely mobile
	< 20 seconds	Moderate fall risk; patient usually independent with basic transfers and many are independent with tub and shower transfers. May go outside and climb stairs
	20-29 seconds	High fall risk; functional abilities vary
	≥ 30 seconds	Very high fall risk; many patients are dependent with chair and toilet transfers and most cannot go outside alone. Few if any can climb stairs independently.
Physical Mobility Scale (PMS): Measures mobility change in the areas of: bed mobility, sit to stand, stand to sit, transfers, ambulation/mobility, sitting and standing balance.	Change in score	Interpretation
	Positive change of 5 points	Improved
	Decrease in score by 4 points	Worsened
Elderly Mobility Scale Score (EMS): This scale assesses 7 dimensions of mobility performance which permit the performance of complex ADLs. Total possible score is 20, where higher scores indicate better performance. The 7 dimensions are: lying to sitting, sitting to lying, sit to stand, standing, gait, timed walk, and functional reach.	Score	Interpretation
	Under 10	Patient is generally dependent in mobility; requires help with basic ADLs, transfers, toileting, and dressing. May require long term care.
	10-13	Patient is generally borderline in terms of safe mobility and independence in ADLs – may require some help with some mobility.
	14-20	Generally able to perform mobility alone and safely and are independent in basic ADLs. Patients usually able to return home but may need some help.
Tinetti Performance Oriented Mobility Assessment Tests measures gait and balance and is scored on the patient's ability to perform specific tasks. Scoring is on a 0-2 scale where 0 represents the most impairment and 2 represents independence. Individual items scores are combined for an overall score (gait score + balance score = overall score).	Score	Interpretation
	Below 19	High risk for falls
	19-24	At risk of falls
	25-28	Low risk of falls
Berg Balance Scale: Measures balance by assessing the performance of functional tasks. The maximum score is 56 points. Functional Tasks: Sitting to standing, Standing to sitting, Standing unsupported, standing unsupported with eyes closed, standing unsupported with feet together Sitting unsupported feet on floor, Transfers, reaching forward with outstretched arm, pick up object from floor, Turning to look behind right and left shoulders, turn 360 degrees, Count number of times step-touch measured stool, standing unsupported one foot in front, standing on one leg	Score	Interpretation
	41 – 56	Low fall risk
	21 – 40	More likely to fall
	0 – 20	High fall risk
	Score	Assistive Device Needs
	49.9 – 51.1	Needs no assistive device
	47 – 49.6	Use of cane needed for outdoors
	44 – 46.5	Use of cane needed indoors and outdoors
	26.7 – 39.6	Needs to use walker at all times
	OCCUPATIONAL THERAPY	
Barthel Index: The therapist scores patient on actual task performance, not what they could do, on 10 specific ADLs (8 self-care; 2 mobility related). ADL information can be obtained from patient self-report, someone familiar with patient's abilities, or from therapist observation.	Score	Assistive Device Needs
	Maximum score 100; higher scores indicate a higher degree of independence.	
Katz Index of Independence in ADLs: Patients are assessed on six functions: bathing, dressing, toileting, transferring, continence, and feeding using the scoring Independent (1 point) or Dependent (0 Points)	Score	Interpretation
	6 = High	Patient is independent
	4 = Moderate	Patient is moderately impaired
	0 = Low	Patient is dependent
Physical Mobility Scale:	SEE ABOVE IN PT	



Functional Reach Test: In standing, measures how far forward the patient can reach without taking a step. This information is correlated with risk of falling.	Measurement in inches		Interpretation					
	10" or greater		Low risk of falls					
	6" to 10"		Risk of falling is 2x greater than normal					
	6" or less		Risk of falling is 4x greater than normal					
Unwilling to reach		Risk of falling is 8x greater than normal						
Arm Curl Test: The patient is instructed to complete as many bicep curls as possible (through the full range of motion) in 30 seconds.	Men's Age	Men's Below Average	Men's Average	Men's Above Average	Women's Age	Women's Below Average	Women's Average	Women's Above Average
	60-64	< 16	16 To 22	> 22	60-64	< 13	13 to 19	> 19
	65-69	< 15	15 to 21	> 21	65-69	< 12	12 to 18	> 18
	70-74	< 14	14 to 21	> 21	70-74	< 12	12 to 17	> 17
	75-79	< 13	12 to 19	> 19	75-79	< 11	11 to 17	> 17
	80-84	< 12	13 to 19	> 19	80-84	< 10	10 to 16	> 16
	85-89	< 11	11 to 17	> 17	85-89	< 10	10 to 15	> 15
	90-94	< 10	10 to 14	> 14	90-94	< 8	8 to 13	> 13
SPEECH THERAPY			Normal	Mild Cognitive Impairment	Alzheimer's Disease			
Montreal Cognitive Assessment (MOCA): Screens for mild cognitive impairment by assessing different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. Total possible score is 30; a score of 26 or greater is considered a normal.			≥ 26	19.0 – 25.2	21.0-11.4			
			*The distinction between Mild Cognitive Impairment and Alzheimer's disease categorization is mostly dependent on the presence of associated functional impairment and not on a specific score of the MOCA.					
Mini-Mental State Exam (MMSE): 30-point questionnaire that is designed to measure cognitive impairment. Also used to estimate the severity and progression of cognitive impairment and to follow the course of cognitive changes in an individual over time.			Method	Score		Interpretation		
			Single Cut-off	< 24		Abnormal		
			Range	< 21 > 25		Increased odds of dementia Decreased odds of dementia		
			Education	21 < 23 < 24		Abnormal for 8 th grade education Abnormal for high school education Abnormal for college education		
			Severity	24-30 18-23 0-17		No cognitive impairment Mild cognitive impairment Severe cognitive impairment		
The Mann Assessment of Swallowing Ability (MASA): Bedside exam of swallowing ability in adults 18 and older. Exam covers 24 clinical items that evaluate oromotor / sensory components of swallowing, prerequisite learning skills such as cooperation and auditory comprehension, baseline cranial nerve function, and functional assessment of swallow.			Severity Grouping	MASA Score- Dysphagia		MASA Score - Aspiration		
			No abnormality detected	≤ 178-200		≤ 170-200		
			Mild	≤ 168-177		≤ 149-169		
			Moderate	≤ 139-167		≤ 148		
			Severe	≤ 138		≤ 140		
VAMC Saint Louis University Mental Status Exam (SLUMS): A series of questions and tasks used to look for presence of cognitive deficits and identify changes over time.			High School Education	Scoring		Less than High School		
			27-30	Normal		25-30		
			21-26	Mild Neurocognitive Disorder		20-24		
			1-20	Dementia		1-19		
Swallowing Ability and Function Evaluation (SAFE): Three stage test: 1) evaluation of general info related to swallowing ability 2) physical exam of oropharyngeal mechanism 3) ability to efficiently, effectively, and safely manage the oral prep phase, oral phase, & pharyngeal phase of the swallow are evaluated.			Score (For each stage)		Interpretation			
			8, 9		Within normal limits			
			6, 7		Mild			
			3, 4, 6		Moderate			
			1, 2		Severe			