

ABOUT THE AUTHOR

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The *Compendium* is a comprehensive reference manual containing an extensive selection of instruments developed to measure signs and symptoms commonly encountered in neurological conditions, both progressive and non-progressive. It provides a repository of established instruments, as well as newly-developed scales, and covers all aspects of the functional consequences of acquired brain impairment.

In particular, the text provides a detailed review of approximately 150 specialist instruments for the assessment of people with neurological conditions such as dementia, multiple sclerosis, stroke and traumatic brain injury. Part A presents scales examining body functions, including consciousness and orientation; general and specific cognitive functions; regulation of behaviour, thought, and emotion; and motor-sensory functions. Part B reviews scales of daily living activities and community participation. Part C focuses on contextual factors, specifically environmental issues, and Part D contains multidimensional and quality of life instruments.

Each instrument is described in a stand-alone report using a uniform format. A brief history of the instrument's development is provided, along with a description of item content and administration/scoring procedures. Psychometric properties are reviewed and a critical commentary is provided. Up to a dozen key references are cited and in most cases the actual scale is included, giving the reader easy access to the instrument. The structure of the book directly maps onto the taxonomy of the influential *International Classification of Functioning, Disability and Health* (World Health Organization, 2001), enabling linkage of clinical concepts across health conditions.

The *Compendium* will be a valuable reference for clinicians, researchers, educators, and graduate students, and a practical resource for those involved in the assessment of people with brain impairment.

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Summary score sheet for the Glasgow Coma Scale
Teasdale and Jennett (1974)

| Name: | Date: | Time: | Assessor: |
|----------------------|------------------------|-------|-----------|
| EYE OPENING | Spontaneous | 4 | |
| | To speech | 3 | |
| | To pain | 2 | |
| BEST VERBAL RESPONSE | Oriented | 5 | |
| | Confused | 4 | |
| | Incomprehensible words | 3 | |
| BEST MOTOR RESPONSE | Obeys commands | 6 | |
| | Localizes pain | 5 | |
| | Withdraws | 4 | |
| TOTAL SCORE: | Flexion to pain | 3 | |
| | Extension to pain | 2 | |
| | None | 1 | |

Acknowledgement: Adapted from Teasdale, G., & Jennett, B. (1974). Assessment of coma and impaired consciousness: A practical scale. *The Lancet*, 304(7202), 81-84. Reprinted by permission of The Lancet, and Jennett, B. (1978). Assessment and prognosis of coma after head injury. *Acta Neurochirurgica*, 34(1-4), 45-55, reprinted by permission of Springer-Verlag.

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Items of the Amnesia Scale for Glasgow Coma Scale – Extended
Neil, Yates, and Kruger (2000)

| Name: | Assessor: | Date: |
|-------|---|-------|
| 7 | No amnesia: client can remember impact, can remember falling and striking a solid surface, etc. | |
| 6 | Amnesia for 30 minutes or less: client regained consciousness while still in vehicle, in street at scene of incident, etc. | |
| 5 | Amnesia of 1/2 hour to 3 hours: remembers being loaded into ambulance, in ambulance on way to hospital, arriving at emergency room, admission to ward, etc. | |
| 4 | Amnesia of 3 to 24 hours: determine duration by constant of the first memory, which will be for an event in the ward or other hospital procedure | |
| 3 | Amnesia of 1 to 7 days | |
| 2 | Amnesia of 8 to 30 days | |
| 1 | Amnesia of 31 to 90 days | |
| 0 | Amnesia greater than 3 months | |
| X | Cannot be scored, e.g., can speak but responses are inappropriate or unintelligible, cannot speak because unconscious, intubated, facial fractures, etc. | |

Acknowledgement: From Neil, V., Yates, D. W., & Kruger, J. (2000). An extended Glasgow Coma Scale (GCS-E) with enhanced sensitivity to mild brain injury. *Archives of Physical Medicine and Rehabilitation*, 81(5), 614-617. Table 1, p. 615, reprinted with permission of the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation and Elsevier.

Sample Pages

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Confusion Assessment Method
Inouye, van Dyck, Alessi, Bakin, Siegel, and Horwitz (1990)

| Name: | Assessor: | Date: |
|-----------------------------------|--|--------|
| 1. ACUTE ONSET | Is there evidence of an acute change in mental status from the patient's baseline? | Yes/No |
| 2. INATTENTION | a) Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said? b) If present at any time during interview c) Present at some time during interview, but in mild form d) Absent at some time during interview, in mild form e) Absent f) Present or abnormal: Did this behaviour fluctuate during the interview, that is, tend to come and go or increase and decrease in severity? | |
| 3. DISORGANIZED THINKING | Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? | |
| 4. ALTERED LEVEL OF CONSCIOUSNESS | Overall, how would you rate the patient's level of consciousness? Alert (normal) Vigilant (hyper-alert, overly sensitive to environmental stimuli, started very easily) Lethargic (drowsy, easily aroused) Stupor (difficult to arouse) Coma (unarousable) Uncertain | |
| 5. DISORIENTATION | Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day? | |
| 6. MEMORY IMPAIRMENT | Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions? | |
| 7. PERCEPTUAL DISTURBANCES | Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions, or misperceptions such as thinking something was moving when it was not? | |
| 8. PSYCHOMOTOR ACTIVITY | Part 1: PSYCHOMOTOR AGITATION At any time during the interview, did the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent sudden changes of position? Part 2: PSYCHOMOTOR RETARDATION At any time during the interview, did the patient have an unusually decreased level of motor activity, such as sluggishness during the interview, staying in one position for a long time, or moving very slowly? | |
| 9. ALTERED SLEEP-WAKE CYCLE | Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night? | |

The questions listed under this topic (pre-factor) were repeated for each topic where applicable.

Cognitive Log (Cog-Log).

General Practitioner Assessment of Cognition (GPCOG).

Hopkins Competency Assessment Test (HCAT).

Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE).

Mini-Cog.

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Rowland Universal Dementia

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Behavioral Dyscontrol Scale (BDS).

Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD).

Behavior Rating Inventory of Executive Function (BRIEF).
Cohen-Mansfield Agitation Inventory (CMAI).

Fatigue Impact Scale (FIS).
Fatigue Severity Scale (FSS).
Frontal Behavioral Inventory (FBI).

Frontal Systems Behavior Scale (FrSBe).

Harmful Behaviours Scale (HBS).

Katz Adjustment Scale – Form R1 (KAS-R1).

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Ian D. Cameron, Introduction.

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Katz Index of Activities of Daily Living (KIADL).

Instrumental Activities of Daily Living Scale (IADLS) and Physical Self-Maintenance Scale (PSMS).

Northwick Park Dependency Score (NPDS).

Nottingham Activities of Daily Living Scale (NADLS).

Nottingham Extended Activities of Daily Living (NEADL).

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Système de Mesure de l'Autonomie Fonctionnelle (SMAF; English version: Functional Autonomy Measurement System).

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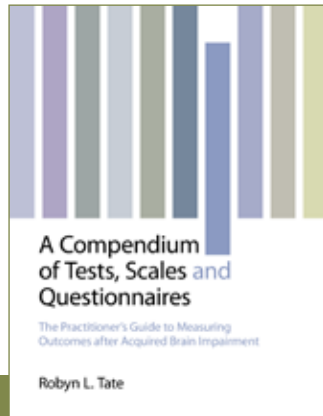
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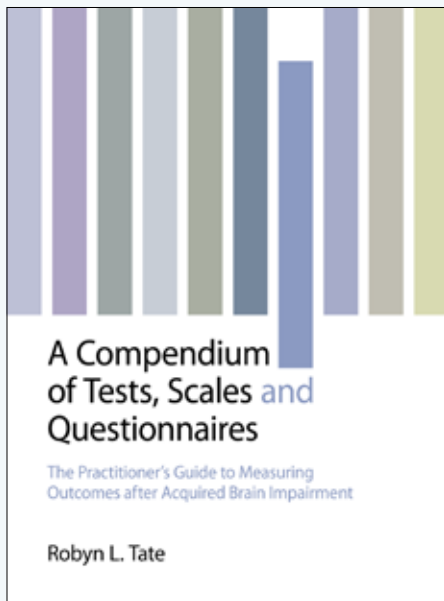
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