DEPRESSION SCREENING

DIRECTIONS: Interview the resident whenever possible; the caregiver when resident is unable to respond. Select the appropriate frequency for both questions in the PHQ-2© and record the score in the provided field. Select the symptom for each line as reported then select the reporter of that symptom. Note that both individuals could report the symptom as well as just the resident or the caregiver. Referrals to other clinicians and physicians should be based on the findings of the screening.

Primary diagnosis:_____

Ask the resident, *"Over the last two weeks, how often have you been bothered by any of the following problems?"*

PHQ-2©*	Not at All 0-1 Day	Several Days 2-6 Days	More Than Half of the Days 7-11 Days	Nearly Every Day 12-14 Days	N/A Unable to Respond
a) Little interest or pleasure in doing things	❍ 0	❍ 1	❍ 2	❍ 3	❍ N/A
b) Feeling down, depressed or hopeless	❍ 0	❍ 1	❍ 2	❍ 3	❍ N/A

SCORE ☐ Notify Physician if either score is 2 or 3 then continue asking the questions below. Report presence of any of the 7 symptoms to the physician as well. If score for a) and b) is 0 or 1, END the PHQ interview.

SYMPTOMS	REPORTED BY	
	RESIDENT	CAREGIVER
Trouble falling or staying asleep, or sleeping too much	❑	❑
Feeling tired or having little energy	❑	❑
Poor appetite or overeating	❑	❑
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	❑	❑
Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	❑	❑
Thoughts that you would be better off dead, or of hurting yourself in some way	❑	❑

History of drug or alcohol abuse? ❍ No ❍ Yes, Date:_____

History of depression? ❍ No ❍ Yes, Date:_____

Chronic pain? ❍ No ❍ Yes, Date:_____

Other diagnoses, medications or circumstances that trigger or contribute to depression (i.e., steroid use, hypothyroidism):

_____

COMMENTS

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Screener Signature/Title:_____ Date:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed