Southern Health Santé Sud

ADDRESSOGRAPH OR LABEL

GERIATRIC DEPRESSION SCALE (GDS) – SHORT FORM

Instructions for completion on the back.

Question	Answer	Score
1. Are you basically satisfied with your life?	YES / NO	
2. Have you dropped many of your activities and interests?	YES / NO	
3. Do you feel that your life is empty?	YES / NO	
4. Do you often get bored?	YES / NO	
5. Are you in good spirits most of the time?	YES / NO	
6. Are you afraid that something bad is going to happen to you?	YES / NO	
7. Do you feel happy most of the time?	YES / NO	
8. Do you often feel helpless?	YES / NO	
9. Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10. Do you feel you have more problems with memory than most?	YES / NO	
11. Do you think it is wonderful to be alive?	YES / NO	
12. Do you feel pretty worthless the way you are now?	YES / NO	
13. Do you feel full of energy?	YES / NO	
14. Do you feel that your situation is hopeless?	YES / NO	
15. Do you think that most people are better off than you are?	YES / NO	
	TOTAL	

Completed by (name, signature and designation):

Date and time:

Scoring:

Assign one point for each of these answers:

1. NO	2. YES	3. YES	4. YES	5. NO
6. YES	7. NO	8. YES	9. YES	10. YES
11. NO	12. YES	13. NO	14. YES	15. YES

A score of 0 to 5 is normal. A score above 5 suggests depression.

Source: *Yesavage J.A., Brink T.L., Rose T.L. et al. Development and validation of a geriatric depression screening scale: a preliminary report. J. Psychiatr. Res. 1983; 17:37-49.*

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Instructions for Completion:

1. *Complete this screening tool minimally quarterly. A resident may be screened at any time in addition to quarterly.*
2. *This tool is intended for use with residents who have no to mild cognitive impairment.*
3. *Ask the resident these questions about how he/she felt over the* ***past week*** *and record his/her answers. Answers to these questions must not come from other sources (e.g. family or staff).*
4. *Circle the resident's response to each question.*
5. *Refer to the scoring table below and give a point under the score column if the answer the resident provided merits a point.*
6. *If the resident's depression screening is not suggestive of depression, note this on the correct review form (i.e. quarterly or annual) and file the screening tool in the health record.*
7. *If the resident's depressing screening is suggestive of depression, the nurse or designate shares this finding with the prescriber.*
8. *If the resident's depression screening is suggestive of depression, ask the resident: Do you ever think about hurting or harming yourself? If yes, what would you do?*
9. *Develop a plan of care together with the resident and/or his/her substitute decision maker and the prescriber and document the plan and interventions on the Integrated Care Plan. File the screening tool on the health record when the care plan is developed.*