

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ DATE \_\_\_\_\_

# Cornell Scale for Depression in Dementia

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

## SCORING SYSTEM

a = Unable to evaluate      0 = Absent  
 1 = Mild to Intermittent      2 = Severe

Score greater than 12 = Probable Depression

### A. MOOD-RELATED SIGNS

1. Anxiety; anxious expression, rumination, worrying
2. Sadness; sad expression, sad voice, tearfulness
3. Lack of reaction to pleasant events
4. Irritability; annoyed, short tempered

a	0	1	2

### B. BEHAVIORAL DISTURBANCE

5. Agitation; restlessness, hand wringing, hair pulling
6. Retardation; slow movements, slow speech, slow reactions
7. Multiple physical complaints (score 0 if gastrointestinal symptoms only)
8. Loss of interest; less involved in usual activities (score 0 only if change occurred acutely, i.e., in less than one month)

a	0	1	2

### C. PHYSICAL SIGNS

9. Appetite loss; eating less than usual
10. Weight loss (score 2 if greater than 5 pounds in one month)
11. Lack of energy; fatigues easily, unable to sustain activities

a	0	1	2

### D. CYCLIC FUNCTIONS

12. Diurnal variation of mood; symptoms worse in the morning
13. Difficulty falling asleep; later than usual for this individual
14. Multiple awakenings during sleep
15. Early morning awakening; earlier than usual for this individual

a	0	1	2

### E. IDEATIONAL DISTURBANCE

16. Suicidal; feels life is not worth living
17. Poor self-esteem; self-blame, self-depreciation, feelings of failure
18. Pessimism; anticipation of the worst
19. Mood congruent delusions; delusions of poverty, illness or loss

a	0	1	2

NOTES/CURRENT MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

ASSESSOR: \_\_\_\_\_

Score

#### Instruction for use: (Cornell Dementia Depression Assessment Tool)

1. The same CNA (certified nursing assistant) should conduct the interview each time to assure consistency in the response.
2. The assessment should be based on the patient's normal weekly routine.
3. If uncertain of answers, questioning other caregivers may further define the answer.
4. Answer all questions by placing a check in the column under the appropriate-ly numbered answer. (a=unable to evaluate, 0=absent, 1=mild to intermittent, 2=severe).
5. Add the total score for all numbers checked for each question.
6. Place the total score in the "SCORE" box and record any subjective observation notes in the "Notes/Current Medications" section.
7. Scores totaling twelve (12) points or more indicate probable depression.