

DEMENTIA SCREENING QUESTIONNAIRE FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (DSQIID)

**Professor Shoumitro Deb, MBBS, FRCPsych, MD
Clinical Professor of Neuropsychiatry & Intellectual Disability,
University of Birmingham, Division of Neuroscience,
Queen Elizabeth Psychiatric Hospital,
Mindelsohn Way,
Birmingham B15 2QZ, U.K.
E-mail: s.deb@bham.ac.uk
URL: www.bham.ac.uk/psychiatry**

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References

Deb S., Hare M., Prior L. & Bhaumik S. (2007) Dementia Screening Questionnaire for Individuals with Intellectual Disabilities (DSQIID). *British Journal of Psychiatry*, 190, 440-444.

Deb S., Hare M. & Prior L. (2007) Symptoms of dementia among adults with Down's syndrome: a qualitative study. *Journal of Intellectual Disability Research*, 51, 9, 726-739.

NAME OF THE PERSON:

ADDRESS:

DATE OF BIRTH:

NAME OF THE CARER COMPLETING DSQIID:

RELATION OF THE CARER WITH THE PERSON:

DATE OF COMPLETION OF DSQIID:

DATE OF COMPLETION OF DSQIID LAST TIME:

NAME OF THE PERSON ADMINISTERING DSQIID:

THE POSITION OF THE ADMINISTERING PERSON:

PLACE OF COMPLETION OF DSQIID:

FEMALE MALE

PHYSICAL DISABILITY:

- None
 - Problems with vision/ blind
 - Problems with hearing/ deaf
 - Other – please specify
-

OTHER MEDICAL CONDITIONS:

- None
 - Present – please specify
-
-

PSYCHOLOGICAL/ BEHAVIOURAL PROBLEMS:

- None
 - Present – please specify
-

CURRENT MEDICATION (please specify):

PART 1: LEVEL OF 'BEST' ABILITY

Please indicate the level of 'best' ability the person has, or has had, by the appropriate boxes.

SPEECH:

- Could speak fluently and understandably
- Could make short sentences
- Could speak only a few words
- Could not speak much but used sign language
- Could not speak and did not use sign language

DAILY LIVING SKILLS (e.g. Dressing, washing, eating etc.):

- Could live independently with minor help
- Could live independently but needed a lot of help with self help skills
- Could not live independently and needed minor help with self help skills
- Could not live independently and needed a lot of help with self help skills

CURRENT ACCOMMODATION:

- On his/her own
- With relatives
- In a shared, staffed house
- In a group home with full time staff
- In a nursing home with full nursing care
- Other _____

OTHER RELEVANT INFORMATION:

PART 2

Please complete the following questions by the appropriate box.

Example: Question 1) Cannot wash and/or bathe without help.

If the person has always needed help with washing and bathing in his or her adult life, please 'Always been the case'.

If the person's previous skills in this area seem to have deteriorated, 'Always, but worse'.

If the person had the skill in their adult life and has recently lost this skill, please 'New symptom'.

Finally, if the question does not apply to the person (in this case, if the person can wash without help and this has not changed), please 'Does not apply'.

	Always been the case	Always, but worse	New symptom	Does not apply
Cannot wash and/or bathe without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot dress without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dresses inappropriately (e.g. Back to front, incomplete)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undresses inappropriately (e.g. In public)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needs help eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needs help using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinent (including occasional accidents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Always been the case	Always, but worse	New symptom	Does not apply
Does not initiate conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot find words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot follow simple instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot follow more than one instruction at a time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stops in the middle of a task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot write (including printing own name)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Always been the case	Always, but worse	New symptom	Does not apply
Changed sleep pattern (sleeping more or sleeping less)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wakes frequently at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confused at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeps during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wanders at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot find way in familiar surroundings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses track of time (time of day, day of the week, seasons)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Always been the case	Always, but worse	New symptom	Does not apply
Not confident walking over small cracks, lines on the ground or uneven surfaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsteady walk, loses balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot walk unaided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot recognise familiar person (staff/ relatives)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot remember names of familiar persons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot remember recent events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdraws from social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdraws from persons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Always been the case	Always, but worse	New symptom	Does not apply
Loss of interest in hobbies and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seems to go into own world	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive or repetitive behaviour (e.g. Empties cupboards repeatedly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hides or hoards objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puts familiar things into wrong places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Always been the case	Always, but worse	New symptom	Does not apply
Does not know what to do with familiar objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appears insecure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appears anxious or nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appears depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shows aggression (Verbal or physical)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fits/ Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talks to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 3

Finally, please answer the following questions by ticking 'yes' or 'no'.

	Yes	No
Lost some skills (e.g. Brushing teeth)	<input type="checkbox"/>	<input type="checkbox"/>
Speaks (or signs) less	<input type="checkbox"/>	<input type="checkbox"/>
Seems generally more tired	<input type="checkbox"/>	<input type="checkbox"/>
Appears tearful, gets more easily upset	<input type="checkbox"/>	<input type="checkbox"/>
Appears generally slower	<input type="checkbox"/>	<input type="checkbox"/>
Slower speech	<input type="checkbox"/>	<input type="checkbox"/>
Appears more lazy	<input type="checkbox"/>	<input type="checkbox"/>
Walks slower	<input type="checkbox"/>	<input type="checkbox"/>
Generally appears more forgetful	<input type="checkbox"/>	<input type="checkbox"/>
Generally appears more confused	<input type="checkbox"/>	<input type="checkbox"/>

