Name of individual: ____________________________

The individual named on this form has been assessed and found to exhibit:

1. Evidence of short-term memory loss: □ Yes □ No
   (If there is no evidence of short-term memory loss, the assessor may go to 4.b, and skip 2 and 3.)

   And

2. **One** or more of the following conditions: (Check all that apply.)
   □ Is not oriented to place or time.
   □ Has limited ability to make him or herself understood through speech, writing, sign language or any other method
     the individual uses to communicate.
   □ Requires hands-on assistance with eating or drinking.
      (If there is no evidence of one of these conditions, the assessor may go to 4.b, and skip 3.)

   And

3. □ One or more of the following behaviors or symptoms which has been exhibited by the individual within the last
   thirty days: (Check all that apply.)
   □ Ability to make decisions about daily life is poor; requires reminders, cues and supervision in
     planning daily routines
   □ Repetitive physical movement / pacing, hand-wringer, fidgeting
   □ History of physical injury to staff / others
   □ Leaves stove on after cooking
   □ Combative
   □ Aggressive / intimidating
   □ Resistive to care
   □ Exit seeking behaviors
   □ Sexual acting out (does not victimize others)
   □ Easily irritated / upset / agitated
   □ Seeks vulnerable or unwilling sexual partners
   □ Seeks / demands constant attention / reassurance
   □ Agitated or wanders at night
   □ Pattern of inability to control own behaviors
   Specify: ____________________________
   □ Repetitive physical movement / pacing, hand-wringer, fidgeting
   □ Unrealistic fears or suspicions
   □ Inappropriate toileting activity
   Specify: ____________________________

   (If there is no evidence of one of these conditions, the assessor may go to 4.b)

4.a □ The individual named on this form has identified characteristics of dementia in categories 1, 2, and 3 above.
   Therefore:
   (1) The staff of any assisted living facility in which the named individual resides must meet the dementia specialty
       training requirements specified in Washington Administrative Code 388-112A, and
   (2) The assisted living facility must obtain the assessment information for the individual as specified in
       WAC 388-78A-2370.

4.b □ This individual does not meet the screening criteria for dementia identified on this form.

_______________________________  ____________________________
QUALIFIED ASSESSOR SIGNATURE  DATE