Instructions for Administration of Mini-Mental Status Examination (MMSE)

The Mini-Mental Status Exam could be administered by the physician, a nurse or an assistant trained in the administration of such tools. The person administering the Mini-Mental Status Exam needs to be sensitive when the patient shows embarrassment about their inability to answer these questions. Patients should be assured by telling them that this is another way of telling how the treatment is affecting their brain tumor. It also needs to be made clear to the patient that it is very important to get this type of information directly from them. The person administering the test needs to understand that either the correct answer is given or not. There should be no partial credit for answers short of the mark.

The MMSE begins with a graded assessment of orientation to place and time, for which a maximum of 10 points is possible. This is followed by testing two aspects of memory. The first is the immediate recall for three objects presented orally, followed by a serial sevens task which is interposed to assess attention, concentration, and calculation, and also to prevent the individual from rehearsing the three objects previously learned. A maximum of 11 points may be obtained in this section of the test.

The final section surveys aphasia by testing functions of naming, repetition, understanding a three-stage command, reading, writing and copying a drawing. There is a maximum of 9 points which may be obtained on this section, for a total possible MMSE score of 30 points.

1. **Orientation**
    1. Ask for: the year, season, date, day, month. Then ask specifically for parts omitted, e.g., "Can you also tell me what season it is?" One point for each correct.

    2. Ask in turn, "Can you tell me the name of this department?" (state, county, town, hospital, floor.) One point for each correct.

2. **Registration**

    Ask the patient if you may test his memory. Then say the names of 3 unrelated objects, clearly and slowly, about one second for each. After you have said all 3, ask him to repeat them. This first repetition determines his score (0-3) but keep saying them until he can repeat all 3, up to 6 trials. If he does not eventually learn all 3, **recall** cannot be meaningfully tested.

3. **Attention and Calculation**

    Ask the patient to begin with 100 and count backward by 7. Stop after 5 subtractions (93, 86, 79, 72, 65). Score the total number of correct answers. If the patient cannot or will not perform his task. ask him to spell the word "world" backward. The score is the number of letters in correct order, e.g., dlrow=5, dlorw=3.

4. **Recall**

    Ask the patient if he can recall the 3 words you previously asked him to remember in the registration section. Score 0-3.

5. **Language**

    NAMING: Show the patient a wrist watch and ask him what it is. Repeat for pencil.
    Score 0-2.

    REPETITION: Ask the patient to repeat the sentence "No ifs, ands, or buts" after you. Allow only one trial. Score 0-1.

3 STAGE COMMAND: Give the patient a piece of plain blank paper and ask him to follow your instructions: "Take the paper in your right hand, fold it in half and put it on the floor." Score 1 point for each part correctly performed.

READING: On a blank piece of paper, print the sentence, "Close your eyes," in letters large enough for the patient to see clearly. Ask him to read it and do what it says. Score 1 point only if he actually closes his eyes.

WRITING: Give the patient a blank piece of paper and ask him to write a sentence for you. Do not dictate a sentence. It is to be written spontaneously. It must contain a subject and a verb and be sensible. Correct grammar and punctuation are not necessary.

COPYING: On a clean piece of paper, draw two intersecting pentagons, each side about 1 inch, and ask him to copy it exactly as it is. All 10 angles must be present and 2 must intersect to score 1 point. Tremor and rotation are ignored.

Estimate the patient's level of sensorium along a continuum, from alert on the left to coma on the right, by drawing a vertical line at the appropriate point in the horizontal line. Record the coded assessment.

SPECIAL CONSIDERATIONS

The examination is conducted so as to minimize stress for the patient. Errors are not indicated to the subjects and, in general, mistakes are not corrected. Refusals are considered to be errors after a minimum of encouragement. Individuals with peripheral impairment such as blindness or restriction of the hands due to arthritis or other peripheral disorders are scored the number correct out of the possible items they could answer given their other noncognitive impairments. Please note these exceptions on the MMSE form. It is important not to allow your administration of this test to be affected by your perception of why the patient may have responded incorrectly or not at all. That is, the examination should be conducted without the examiner modifying the scoring by assumptions of whether or not the individual was motivated, paying attention, or could understand. For the purpose of the exam, the score indicates a failed performance, not necessarily a failed performance under all conceivable circumstances.

Spencer MP, and Folstein MF. The Mini-Mental State Examination. In: PA Keller and LG Ritt (Eds). Innovations in Clinical Practice: A Source Book. Vol 4. Sarasota, FL: Professional Resource Exchange, Inc., 307-308, 1985.