Primary Care Evaluation for a New Patient with Suspected Dementia

OVERVIEW

Philip D. Sloane, MD, MPH and Daniel I Kaufer, MD
Departments of Family Medicine and Neurology
University of North Carolina at Chapel Hill

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Instructions

1. Use this system to evaluate patients whom you suspect have dementia due to a positive screen and/or a suggestive history.

2. Schedule the patient and a family member for two visits: a ½ hour appointment to perform the assessment and order tests, and a 20 minute visit a week or more later to discuss findings.

3. Visit one –
   - Before the visit: the nurse (or provider or pharmacist) completes the medication review form (Form B), and the medical record is reviewed RE reason for visit and known information about the person's health and screening results.
   - The family member completes the family member questionnaire (Form A).
   - The nurse (if trained) or provider complete one of the cognitive status evaluations (Form D.1 or D.2).
   - The medical provider completes the cognitive evaluation history (Form C) and the Examination Checklist (Form E).
   - Any laboratory tests the clinician considers appropriate are ordered and an MRI of the head (without contrast).

4. Visit two –
   - Before the visit: the nurse or provider fills in the numbered portions of the summary (Form F) and gives it to the medical provider to review before the visit.
   - If appropriate (based on information gathered to date) the patient completes the PHQ-9 depression screen (Form G).
   - The provider meets with the patient and family member to discuss the findings. The nurse is involved and helps direct the patient and family to community resources, if appropriate.