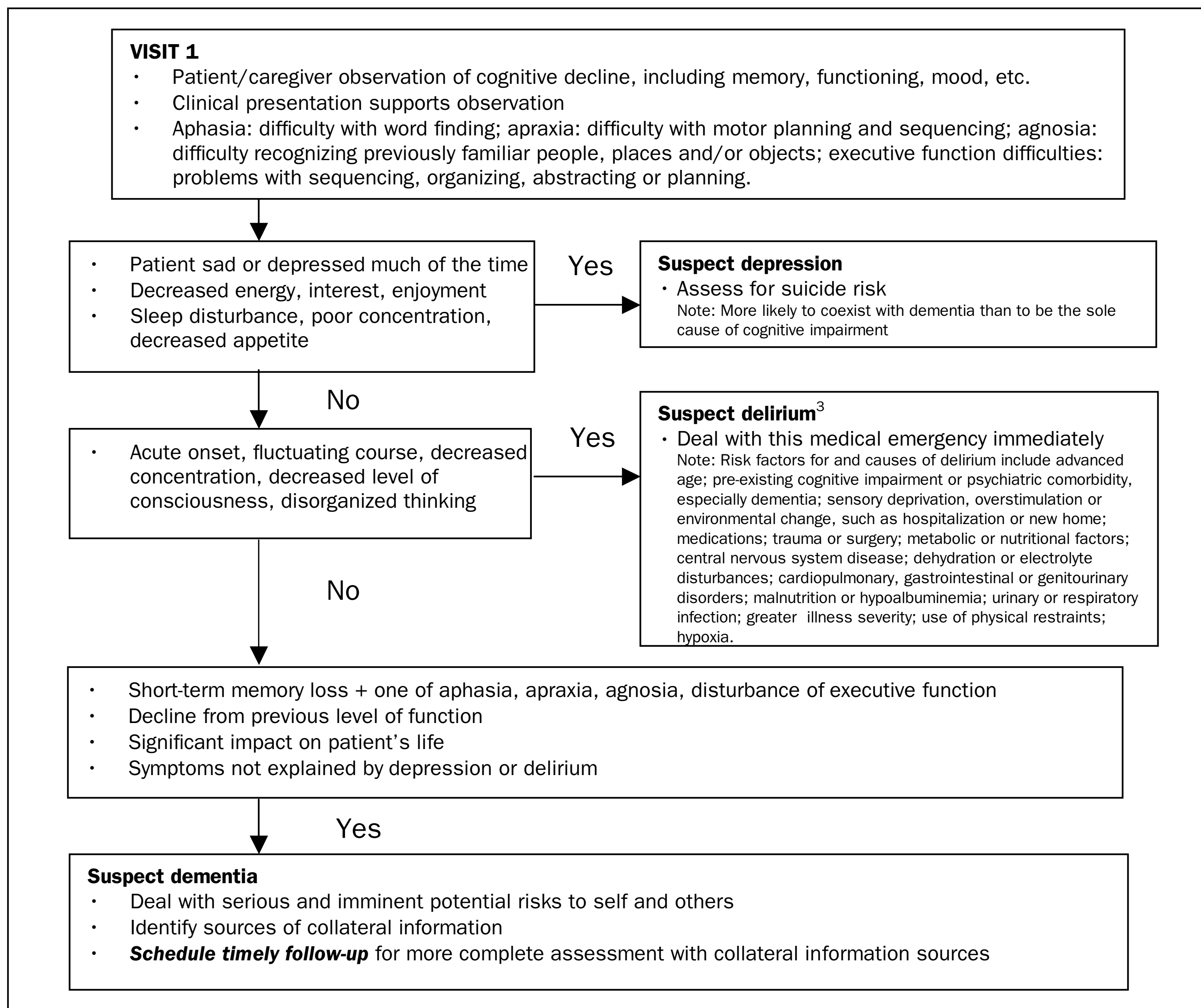
Appendix 1: Assessment of the patient with cognitive impairment



VISIT 2

- Take patient history supported by collateral information
- Document decline including short-term memory + one of aphasia, apraxia, agnosia, disturbance of executive function[2]
- Perform objective test of cognition:[4] MMSE +/-clock drawing, Trails, Time and change, Word list; MOCA or DemTect[20]
- Document decline in ADLs and IADLs
  - ADL: **D**ressing, **E**ating, **A**mbulation, **T**oilet, **H**ygiene (mnemonic DEATH)
  - IADLs: **S**hopping, **H**ousework, **A**ccounting and banking, **F**ood preparation, **T**ransportation (mnemonic SHAFT)
- Ask caregiver about concerns/problems
- Check for caregiver stress
- Re-explore safety issues
- Order basic laboratory tests: CBC, TSH, serum electrolytes, creatinine, calcium and glucose[5]
- Imaging not routinely indicated
- ***Schedule follow-up***

Notes: Education, culture, language barriers, and sensory impairment can affect an individual's ability to perform certain tasks. Additional investigations are not recommended unless indicated by atypical findings in history, physical examination and initial investigations.

VISIT 3

- Perform physical examination, noting focal or lateralizing signs, gait disturbance, extrapyramidal symptoms
- Review information and laboratory tests
- If a diagnosis of dementia is not supported, follow patient as indicated. Mild cognitive impairment (memory loss without functional impairment or other cognitive impairment): follow carefully q 3–6 months as patient may progress to dementia within a short period of time.

Diagnosis of dementia supported:[3] formulate etiologic diagnosis

- Gradual onset and progression suggest *Alzheimer disease*
- Abrupt onset and stepwise decline suggest *vascular dementia*
- Early behaviour problems, decreased interpersonal skills, loss of social awareness suggest *frontotemporal dementia*
- Fluctuating cognition, pronounced variation in attention and alertness, recurrent visual hallucinations and spontaneous motion features of Parkinsonism suggest *dementia with Lewy bodies*
- Gait disturbance and urinary incontinence in context of cognitive impairment suggest *normal pressure hydrocephalus*
- ***Schedule follow-up within 1 month*** with patient and caregiver for information exchange

VISIT 4

- Discuss diagnosis and general prognosis[1]
- Maintain or develop relationship with patient and caregiver
- Refer to Alzheimer Society for education and support
- Refer to home care where appropriate
- Address safety issues with patient/caregiver
- Discuss future planning with patient/caregiver: power of attorney for finances and personal care; will; advance directives
- Discuss caregiver stress
- Treat systolic hypertension
- Encourage exercise
- Caution re: change in environment or elective hospitalization
- Discuss trial of cholinesterase therapy: may require separate visit
- ***Plan follow-up q 3 months***

Average survival for patients with Alzheimer disease is approximately 10 years, with a range of 2–20 years from onset of memory loss.

Adapted with permission from: Alberta Medical Association, Top/Clinical Practice Guideline. Cognitive Impairment: Is This Dementia? Symptoms to Diagnosis (2007 update). Accessible at <www.topalbertadoctors.org>, under clinical practice guidelines.

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