DEMENTIA/MILD COGNITIVE IMPAIRMENT REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - NEUROLOGY •92 CAMPUS DRIVE, SUITE B, SCARBOROUGH, ME • (207) 883-1414

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Rapid over days/weeks

Rapid over hours/days- rule out delirium

EXAM:
Cognitive exam documented

SUGGESTED PREVISIT WORKUP

If delirium suspected recommend medical evaluation prior to neuro consult: Consider Metabolic, infectious, toxic, traumatic, hormonal, nutritional, sleep disorder, psychiatric

LABS:
CMP, CBC, Tox, TSH, LFT, UA, CT/MRI, LP?

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Progressive cognitive decline over weeks/months /years

Candidate for clinical trial for dementia

Atypical features (park.)/young onset
Transfer of care

EXAM:
MOCA/MMSE abnormal or functionality impaired

SUGGESTED WORKUP

May start Acetylcholinesterase Inhibitor prior to visit if dementia diagnosis is clear

If considering Dementia trial- avoid changing/adjusting meds

LABS:
CT or MRI recommended
TSH, B12, RPR, Lyme, Testosterone

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Mild to moderate dementia in elderly patient without atypical features

Symptoms resolving

Critically/terminally ill

Normal exam “worried patient/family”

Good Geri/Geripsych f/u

EXAM:
MOCA 30/30, MMSE 30/30

SUGGESTED MANAGEMENT

Assess for mimickers

Depression/anxiety
OSA
ADD
Meds effect

LABS:
obvious metabolic/toxic/medication source

CLINICAL PEARLS

- Dementia should be managed by PCP
- If prominent features are neuropsychiatric (hallucinations/ paranoid delusions/severe depression/anxiety) consider geriatric psychiatry
- If prominent comorbidities (cardiac/pulmonary/oncological/ metabolic/complicated social issues) consider geriatrics
- Every patient/family with dementia should optimally have a social worker/case manager involved- access association resources

Maine Medical PARTNERS

V1.1 7/21