# DEMENTIA/MILD COGNITIVE IMPAIRMENT REFERRAL GUIDELINE

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## **HIGH RISK**

SUGGESTED EMERGENT CONSULTATION

### SYMPTOMS AND LABS

Rapid over days/weeks

Rapid over hours/days- rule out delirium

#### **EXAM:**

Cognitive exam documented

## **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

## **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 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?

# 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

# 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
- metabolic/complicated social issues) consider geriatrics
- Every patient/family with dementia should optimally have a social worker/case manager involved- access association resources
- If prominent comorbidities (cardiac/pulmonary/oncological/

Maine Medical

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.

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