DEMENTIA/MILD COGNITIVE IMPAIRMENT REFERRAL GUIDELINE

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

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?

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”

EXAM:
MOCA 30/30, MMSE 30/30

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
- 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