



Provider Guide to the Detection and Diagnosis of Dementia

Importance of Diagnosis

- Cognitive problems are common in the elderly, but dementia isn't the only cause.
- Assessment and evaluation can identify potentially treatable and reversible conditions, such as medication side effects.
- Early and accurate diagnosis of dementia can maximize the use of available therapies to help stabilize and slow progression of symptoms in early stages of disease, and improve the quality of life for the patient and their family.
- Knowing and understanding the diagnosis helps families cope with changes and care for the patient.
- Early intervention and referral to community-based programs and services prevents costly hospitalizations and institutionalization, which is beneficial to patients, families and society.

When to Assess

- Screening for cognitive impairment is not recommended for older adults who exhibit no signs or symptoms.
- Experts suggest that assessment occur when concerns are expressed (personally or from a reliable informant, such as the family caregiver and/or staff).
- When "Warning Signs in a Health Care Setting" are present ("Provider Guide to Understanding Dementia", page 3), or during the Medicare Annual Wellness Visit health risk assessment.

How to Assess

- Use the "Provider Guide to Understanding Dementia", page 2 and/or ACT on Alzheimer's provider practice tools and training videos.
- Despite language and cultural barriers, the assessment can be conducted. Some assessment tools are available in multiple languages.
- The most powerful tool to aid diagnosis is speaking with the person who knows the patient: the family caregiver.
- The assessment and evaluation process is expected to occur over multiple visits that could employ a multidisciplinary care team.
- If dementia is a concern, review medical records in advance and obtain preliminary history from the caregiver prior to the appointment (via phone, mail, or online).

Dementia Screening and Diagnosis in the Primary Care Office

Cognitive Complaint or Decline in Cognitive Function Observed

- By the patient
- By the family and/or caretaker
- By the primary care provider (PCP), allied health professional (AHP), clinic team member



Screen for Cognitive and Functional Impairment

- Consider brief cognitive tests: AD8 Dementia Screening Interview (Box 1), General Practitioner Assessment of Cognition-GPCOG (Box 2), or Mini-Cog (Box 3)
- Conducted by PCP, AHP, Clinic Team Member

Normal



- Reassure
- Reassess in 1 year
- Educate about Brain Health
 - "Promoting Brain Health" handouts/posters
- Consider referral to:
 - Social Worker
 - Physical Therapy/Balance Training
 - Home Health
- Medicare Annual Wellness Visit

Abnormal



Initial Evaluation

- Goal: Identify comorbid conditions/contributing factors
- Invite family and/or caretaker
- Conducted by PCP or AHP
- Warning Signs (Box 4)

History (Box 5)

- Present Illness/Symptoms
- Past Medical History
- Medications
- Social History
- Substance Use (Alcohol/Tobacco/Other)
- Depression Screening-Patient Health Questionnaire-9 (Box 6)

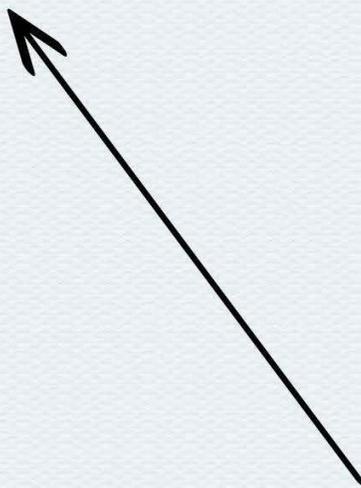
Physical Examination (Box 7)

Mental Status Examination (Box 7)

- Delirium Screening-Confusion Assessment Method (Box 8)

Laboratory Tests (Box 9)

Normal



No Obvious Medical Diagnosis and Suspect Dementia



Detailed Evaluation

Abnormal

Medical diagnosis-treat and follow-up





Detailed Evaluation

- 2-3 visits
- Invite family and/or caretaker
- Conducted by PCP or refer to neurologist, geriatric psychiatrist, geriatrician, or neuropsychologist

History (see above)

Examination (see above)

Laboratory Tests (see above)

Cognitive and Functional Assessment

- Montreal Cognitive Assessment-MOCA (Box 10)
- 6 Item Cognitive Impairment Test-6 CIT (Box 11)
- Others (Box 12)
- Katz Index of Independence in Activities of Daily Living (Box 13)
- Lawton Instrumental Activities of Daily Living Scale (Box 14)

Normal

Abnormal

- Reassure
- Reassess in 1 year
- Educate about Brain Health
 - "Promoting Brain Health" handouts/posters
- Consider referral to:
 - Social Worker
 - Physical Therapy/Balance Training
 - Home Health
- Medicare Annual Wellness Visit

- Medical diagnosis, treat and follow-up
- Consider neuropsychological testing (Box 15)
- Consider additional laboratory tests
- Consider structural neuroimaging (Box 16)
 - CT Scan, MRI

No Dementia Detected

Dementia

- Reassure
- Reassess in 1 year
- Educate about Brain Health
 - "Promoting Brain Health" handouts/posters
- Consider referral to:
 - Social Worker
 - Physical Therapy/Balance Training
 - Home Health
- Medicare Annual Wellness Visit

- "Provider Guide to Communication, Support, and Management of Dementia"
- Disclose the diagnosis
- Document the diagnosis in the patient's medical record
- Provide information
- Address social issues
 - driving, finances, legal
- Refer to community resources
- Treat and follow-up or refer for treatment

Referral/Consultation

- Refer to a specialist, where available, when the diagnosis is unclear (psychiatric vs. cognitive symptoms, movement disorder, unusual symptoms, complex presentation).
- PCPs should consult a specialist (psychiatrist, neurologist, psychologist, etc.) if the patient's safety is in question, the patient is actively psychotic, or the treatment response is inadequate.
- For consultation with a specialist, call a local California Alzheimer's Disease Center (Box 17).



Box 1: AD 8 Dementia Screening Interview

AD8 Dementia Screening Interview

Patient ID#: _____

CS ID#: _____

Date: _____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, *Neurology* 2005;65:559-564
 Copyright 2005. The AD8 is a copyrighted instrument of the Alzheimer's Disease Research Center, Washington University, St. Louis, Missouri.
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Box 1: AD 8 Dementia Screening Interview Instructions

The AD8 Administration and Scoring Guidelines

A spontaneous self-correction is allowed for all responses without counting as an error.

The questions are given to the respondent on a clipboard for self-administration or can be read aloud to the respondent either in person or over the phone. It is preferable to administer the AD8 to an informant, if available. If an informant is not available, the AD8 may be administered to the patient.

When administered to an informant, specifically ask the respondent to rate change in the patient.

When administered to the patient, specifically ask the patient to rate changes in his/her ability for each of the items, **without** attributing causality.

If read aloud to the respondent, it is important for the clinician to carefully read the phrase as worded and give emphasis to note changes due to cognitive problems (not physical problems). There should be a one second delay between individual items.

No timeframe for change is required.

The final score is a sum of the number items marked "Yes, A change".

Interpretation of the AD8 (Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, *Neurology* 2005;65:559-564)

A screening test in itself is insufficient to diagnose a dementing disorder. The AD8 is, however, quite sensitive to detecting early cognitive changes associated many common dementing illness including Alzheimer disease, vascular dementia, Lewy body dementia and frontotemporal dementia.

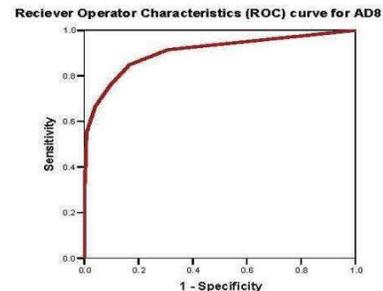
Scores in the impaired range (see below) indicate a need for further assessment. Scores in the "normal" range suggest that a dementing disorder is unlikely, but a very early disease process cannot be ruled out. More advanced assessment may be warranted in cases where other objective evidence of impairment exists.

Based on clinical research findings from 995 individuals included in the development and validation samples, the following cut points are provided:

- 0 – 1: Normal cognition
- 2 or greater: Cognitive impairment is likely to be present

Administered to either the informant (preferable) or the patient, the AD8 has the following properties:

- Sensitivity > 84%
- Specificity > 80%
- Positive Predictive Value > 85%
- Negative Predictive Value > 70%
- Area under the Curve: 0.908; 95%CI: 0.888-0.925



Box 1: AD 8 Dementia Screening Interview Continued

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Box 2: General Practitioner Assessment of Cognition (GPCOG)

Patient name: _____

Date: _____

GPCOG Screening Test

Step 1: Patient Examination

Unless specified, each question should only be asked once

Name and Address for subsequent recall test

1. "I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington." (Allow a maximum of 4 attempts).

Time Orientation

Correct Incorrect

2. What is the date? (exact only)

Clock Drawing – use blank page

3. Please mark in all the numbers to indicate the hours of a clock (correct spacing required)
4. Please mark in hands to show 10 minutes past eleven o'clock (11.10)

Information

5. Can you tell me something that happened in the news recently? (Recently = in the last week. If a general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).

Recall

6. What was the name and address I asked you to remember

John	<input type="checkbox"/>	<input type="checkbox"/>
Brown	<input type="checkbox"/>	<input type="checkbox"/>
42	<input type="checkbox"/>	<input type="checkbox"/>
West (St)	<input type="checkbox"/>	<input type="checkbox"/>
Kensington	<input type="checkbox"/>	<input type="checkbox"/>

(To get a total score, add the number of items answered correctly)
Total correct (score out of 9) /9

If patient scores 9, no significant cognitive impairment and further testing not necessary.
If patient scores 5-8, more information required. Proceed with Step 2, informant section.
If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

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To access the GPCOG in multiple languages, visit the official website:

<http://gpcog.com.au/>



Box 2: General Practitioner Assessment of Cognition (GPCOG) Continued

Informant Interview

Date: _____

Informant's name: _____

Informant's relationship to patient, i.e. informant is the patient's: _____

These six questions ask how the patient is compared to when s/he was well, say 5 – 10 years ago

Compared to a few years ago:

- | | Yes | No | Don't Know | N/A |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| ▪ Does the patient have more trouble remembering things that have happened recently than s/he used to? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▪ Does he or she have more trouble recalling conversations a few days later? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▪ When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▪ Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is the patient less able to manage his or her medication independently? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does the patient need more assistance with transport (either private or public)?
(If the patient has difficulties due only to physical problems, e.g. bad leg, tick 'no') | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(To get a total score, add the number of items answered 'no', 'don't know' or 'N/A')

Total score (out of 6)

If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.

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To access the GPCOG in multiple languages, visit the official website:

<http://gpcog.com.au/>

Box 3: Mini-Cog™

MINI-COG™

Instructions

ADMINISTRATION	SPECIAL INSTRUCTIONS																								
<p>1. Get patient's attention and ask him or her to remember three unrelated words. Ask patient to repeat the words to ensure the learning was correct.</p>	<ul style="list-style-type: none"> • Allow patient three tries, then go to next item. • The following word lists have been validated in a clinical study:¹⁻³ <table> <tr> <td>Version 1</td> <td>Version 3</td> <td>Version 5</td> </tr> <tr> <td>• Banana</td> <td>• Village</td> <td>• Captain</td> </tr> <tr> <td>• Sunrise</td> <td>• Kitchen</td> <td>• Garden</td> </tr> <tr> <td>• Chair</td> <td>• Baby</td> <td>• Picture</td> </tr> <tr> <td>Version 2</td> <td>Version 4</td> <td>Version 6</td> </tr> <tr> <td>• Daughter</td> <td>• River</td> <td>• Leader</td> </tr> <tr> <td>• Heaven</td> <td>• Nation</td> <td>• Season</td> </tr> <tr> <td>• Mountain</td> <td>• Finger</td> <td>• Table</td> </tr> </table>	Version 1	Version 3	Version 5	• Banana	• Village	• Captain	• Sunrise	• Kitchen	• Garden	• Chair	• Baby	• Picture	Version 2	Version 4	Version 6	• Daughter	• River	• Leader	• Heaven	• Nation	• Season	• Mountain	• Finger	• Table
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• Daughter	• River	• Leader																							
• Heaven	• Nation	• Season																							
• Mountain	• Finger	• Table																							
<p>2. Ask patient to draw the face of a clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00 (or 20 minutes after 8:00).</p>	<ul style="list-style-type: none"> • Either a blank piece of paper or a preprinted circle (other side) may be used. • A correct response is all numbers placed in approximately the correct positions AND the hands pointing to the 11 and 2 (or the 4 and 8). • These two specific times are more sensitive than others. • A clock should not be visible to the patient during this task. • Refusal to draw a clock is scored abnormal. • Move to next step if clock not complete within three minutes. 																								
<p>3. Ask the patient to recall the three words from Step 1.</p>	<p>Ask the patient to recall the three words you stated in Step 1.</p>																								

Scoring

3 recalled words	Negative for cognitive impairment
1-2 recalled words + normal CDT	Negative for cognitive impairment
1-2 recalled words + abnormal CDT	Positive for cognitive impairment
0 recalled words	Positive for cognitive impairment

References

1. Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry*. 2000;15(11):1021-1027.
2. Borson S, Scanlan JM, Chen P, Ganguli M. The Mini-Cog as a screen for dementia: validation in a population-based sample. *J Am Geriatr Soc*. 2003;51(10):1451-1454.
3. McCarten JR, Anderson P, Kuskowski MA et al. Finding dementia in primary care: the results of a clinical demonstration project. *J Am Geriatr Soc*. 2012;60(2):210-217.

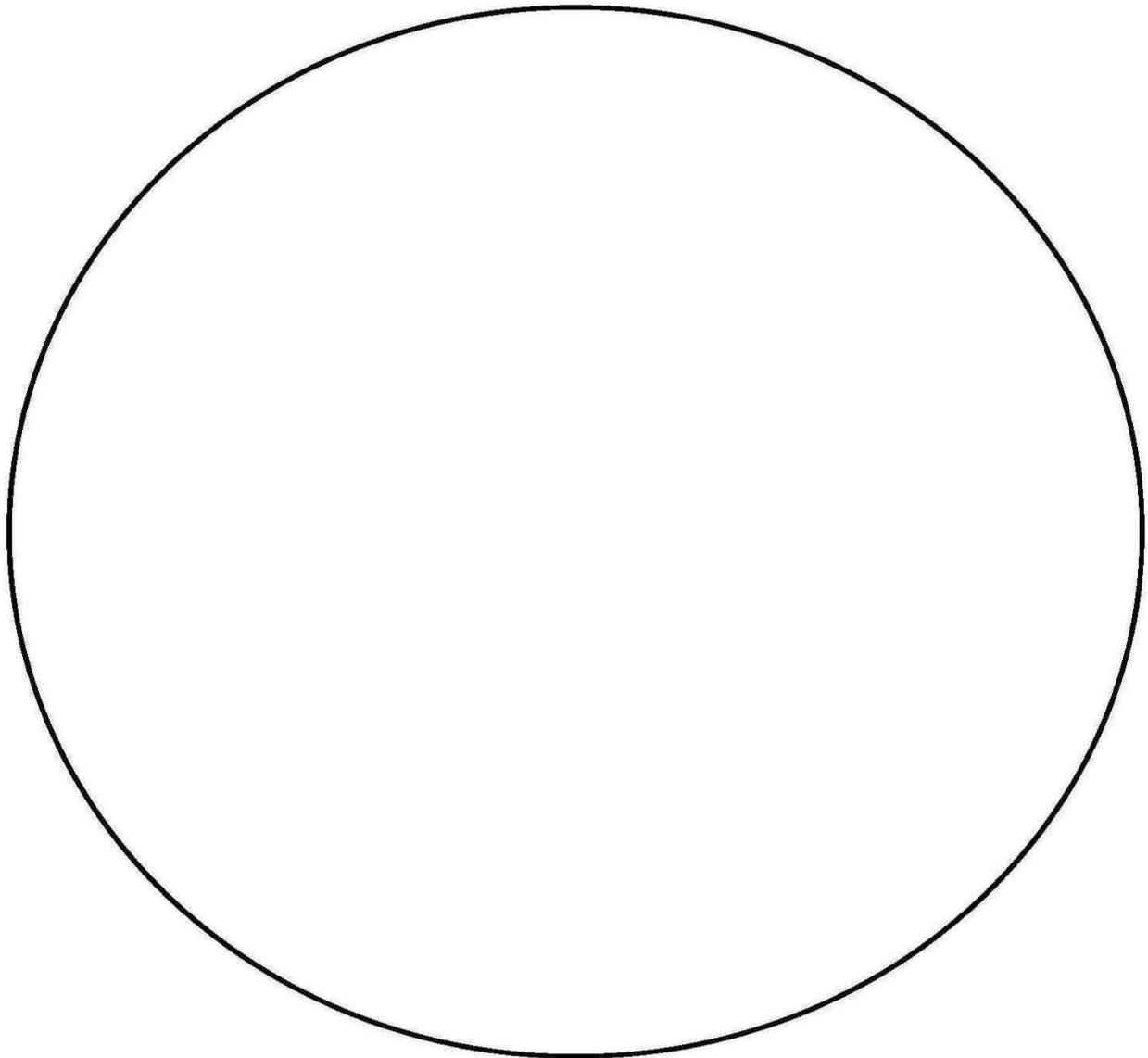
Mini-Cog™ Copyright S Borson. Reprinted with permission of the author (soab@uw.edu). All rights reserved.

Box 3: Mini-Cog™ Continued

CLOCK DRAWING TEST

Patient Name: _____

Date: _____



Box 4: Patient History - Warning Signs



Warning Signs for Dementia in a Health Care Setting



- The individual is confused about the appointment date or location.
- Missed appointments or frequent phone calls by the individual/family to the doctor/health care professional.
- The individual cannot remember recent events or conversations.
- The individual defers to their caregiver/family member to answer questions.
- The individual has difficulty with medical/social/family history.
- The individual is dressed inappropriately and/or has poor hygiene.
- New onset of depression or social withdrawal
- Patient is confused about medications
- Increased emergency room visits
- Frequent Falls
- Weight loss



The presence of any of these warning signs may warrant assessment and further evaluation.



Box 5: Patient History

- Description and nature of symptoms
 - cognitive
 - functional
 - behavioral
- Onset and progression of symptoms
- Family history of dementia
 - age of onset
 - symptoms
 - progression
- Past medical history
 - recent falls or trauma
- Medications
 - recent changes
 - use of anticholinergics, antipsychotics, narcotics
- Substance use (Alcohol/Tobacco/Other)
- Social history
 - education
 - occupation
 - hobbies/interests
 - relationships

Box 6: Depression Screening

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off <i>any problems</i> , how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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<http://www.integration.samhsa.gov/clinical-practice/screening-tools>

Box 6: Depression Screening Instructions

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

Box 7: Examinations

Physical Examination

Complete physical examination, including vital signs, cardiovascular, vision, hearing

Pay particular attention to neurologic and musculoskeletal exam:

- gait and balance
- strength and reflexes (weakness or asymmetry)

Mental Status Examination

-Level of Consciousness (are they awake and alert, lethargic, fluctuating, hypervigilant)

-Appearance and behavior (clothing, grooming, motor behavior)

-Speech and language (spontaneous, hesitation, word finding difficulty, rate, rhythm, and volume)

-Mood (vital sense, feelings of guilt or self-deprecation, outlook on the future, inability to experience pleasure)

-Thought content and process (delusions, hallucinations, bizarre thoughts)

Box 8: Delirium Screening

Confusion Assessment Method (CAM) Algorithm

Note: The diagnosis of delirium requires a present or abnormal rating for criteria 1, 2, and 3 or 4.

1. Acute onset and fluctuating Course

Indicated by positive responses to the following questions:

- Is there evidence of an acute change in mental status from the patient's baseline?

And

- Did this behavior fluctuate during the past day—that is tend to come and go or increase and decrease in severity?

2. Inattention

Indicated by a positive response to the following question:

- Does the patient have difficulty focusing attention—for example, being easily distractible or having difficulty keeping track of what is being said?

3. Disorganized thinking

Indicated by a positive response to the following question:

- Is the patient's speech disorganized or incoherent, with rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

4. Altered level of consciousness

Indicated by any response other than alert (normal) to the following question:

- Overall, how would you rate this patient's level of consciousness?

Alert (normal)

Vigilant (hyperalert)

Lethargic (drowsy, easily aroused)

Stupor (difficult to arouse)

Coma (unarousable)

Adapted from Inouye SK, van Dyck CH, Alessi CA, et al: Clarifying Confusion: the Confusion Assessment Method: A New Method for Detection of Delirium. *Ann Intern Med* 113:941-948,1990

http://www.wai.wisc.edu/pdf/phystoolkit/diagnosis/Confusion_Assessment_Method.pdf

Box 9: Laboratory Testing

- Comprehensive Metabolic Panel (CMP)
- Complete Blood Count (CBC)
- Thyroid Stimulating Hormone (TSH)
- Vitamin B12
- Depending on history and risk factors, also consider:
 - Rapid Plasma Reagin (RPR)
 - HIV screen
 - Erythrocyte Sedimentation Rate (ESR)
 - Carcinoembryonic Antigen Test (CEA)
 - Urinalysis and urine culture

Canadian Medical Association recommendations for the diagnosis of dementia:

Laboratory investigations

- For all patients who have a clinical presentation consistent with Alzheimer disease with typical cognitive symptoms or presentation, only a basic set of laboratory tests should be ordered to rule out causes of chronic metabolic encephalopathy producing chronic confusion and memory loss [grade B recommendation, level 3 evidence; recommendation unchanged].
 - Complete blood count (to rule out anemia)
 - Thyroid stimulating hormone (to rule out hypothyroidism)
 - Serum electrolytes (to rule out hyponatremia)
 - Serum calcium (to rule out hypercalcemia)
 - Serum fasting glucose (to rule out hyperglycemia)
- The serum vitamin B₁₂ level should be determined in all older adults suspected of having dementia or cognitive decline [grade B recommendation, level 2 evidence; new recommendation].
- Older adults found to have a low vitamin B₁₂ level should be given vitamin B₁₂ (either orally or parenterally) because of potential improvement of cognitive function and the deleterious effects of low vitamin B₁₂ levels on multiple organ systems, besides the effects on cognition [grade B recommendation, level 2 evidence; new recommendation].
- Determination of serum folic acid or red blood cell folate levels in older adults in Canada is optional and may be reserved for patients with celiac disease, inadequate diet or other condition that prevents them from ingesting grain products [grade E recommendation, level 2 evidence; new recommendation].
- There is currently insufficient evidence to support the need for the determination of serum homocysteine levels in older adults with suspected dementia or cognitive decline [grade C recommendation, level 3 evidence; new recommendation].
- There is currently insufficient evidence that treatment of elevated serum homocysteine levels affects cognition [grade C recommendation, level 3 evidence; new recommendation].
- Genetic testing, including screening for the apolipoprotein E gene, is not recommended for the purpose of diagnosing Alzheimer disease because the positive and negative predictive values are low [grade E recommendation, level 2 evidence; new recommendation].

Howard H. Feldman MD et al. CMAJ 2008;178:825-836

Box 10: Montreal Cognitive Assessment

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

NAME : _____
Education : _____ Date of birth : _____
Sex : _____ DATE : _____

VISUOSPATIAL / EXECUTIVE		Copy cube		Draw CLOCK (Ten past eleven) (3 points)		POINTS								
		[]	[]	[]	[]		___/5							
		[]	[]	[]	[]									
NAMING														
			[]	[]	[]	___/3								
MEMORY		Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED	No points					
		1st trial	[]	[]	[]	[]	[]							
		2nd trial	[]	[]	[]	[]	[]							
ATTENTION		Read list of digits (1 digit/ sec.).		Subject has to repeat them in the forward order		[]	2	1	8	5	4	___/2		
				Subject has to repeat them in the backward order		[]	7	4	2					
		Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors		[]		F B A C M N A A J K L B A F A K D E A A A J A M O F A A B						___/1		
		Serial 7 subtraction starting at 100		[]	93	[]	86	[]	79	[]	72	[]	65	___/3
				4 or 5 correct subtractions: 3 pts , 2 or 3 correct: 2 pts , 1 correct: 1 pt , 0 correct: 0 pt										
LANGUAGE		Repeat : I only know that John is the one to help today. []		The cat always hid under the couch when dogs were in the room. []								___/2		
		Fluency / Name maximum number of words in one minute that begin with the letter F		[]		_____ (N \geq 11 words)						___/1		
ABSTRACTION		Similarity between e.g. banana - orange = fruit		[]		train - bicycle		[]		watch - ruler		___/2		
DELAYED RECALL		Has to recall words WITH NO CUE		FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only			___/5		
		Category cue		[]	[]	[]	[]	[]						
		Multiple choice cue		[]	[]	[]	[]	[]						
Optional														
ORIENTATION		[] Date		[] Month		[] Year		[] Day		[] Place		[] City		___/6
© Z.Nasreddine MD		www.mocatest.org		Normal $\geq 26 / 30$		TOTAL		___/30		Add 1 point if ≤ 12 yr edu				
Administered by: _____														

To access the MoCA in multiple formats and languages, visit the official website:

<http://www.mocatest.org/>



Box 10: Montreal Cognitive Assessment Instructions

Montreal Cognitive Assessment (MoCA)

Administration and Scoring Instructions

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. Time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

1. Alternating Trail Making:

Administration: The examiner instructs the subject: "Please draw a line, going from a number to a letter in ascending order. Begin here [point to (1)] and draw a line from 1 then to A then to 2 and so on. End here [point to (E)]."

Scoring: Allocate one point if the subject successfully draws the following pattern: 1 -A- 2- B- 3- C- 4- D- 5- E, without drawing any lines that cross. Any error that is not immediately self-corrected earns a score of 0.

2. Visuoconstructional Skills (Cube):

Administration: The examiner gives the following instructions, pointing to the cube: "Copy this drawing as accurately as you can, in the space below".

Scoring: One point is allocated for a correctly executed drawing.

- Drawing must be three-dimensional
- All lines are drawn
- No line is added
- Lines are relatively parallel and their length is similar (rectangular prisms are accepted)

A point is not assigned if any of the above-criteria are not met.

3. Visuoconstructional Skills (Clock):

Administration: Indicate the right third of the space and give the following instructions: "Draw a clock. Put in all the numbers and set the time to 10 past 11".

Scoring: One point is allocated for each of the following three criteria:

- Contour (1 pt.): the clock face must be a circle with only minor distortion acceptable (e.g., slight imperfection on closing the circle);
- Numbers (1 pt.): all clock numbers must be present with no additional numbers; numbers must be in the correct order and placed in the approximate quadrants on the clock face; Roman numerals are acceptable; numbers can be placed outside the circle contour;
- Hands (1 pt.): there must be two hands jointly indicating the correct time; the hour hand must be clearly shorter than the minute hand; hands must be centred within the clock face with their junction close to the clock centre.

A point is not assigned for a given element if any of the above-criteria are not met.

Box 10: Montreal Cognitive Assessment Instructions Continued

4. Naming:

Administration: Beginning on the left, point to each figure and say: "Tell me the name of this animal".

Scoring: One point each is given for the following responses: (1) lion (2) rhinoceros or rhino (3) camel or dromedary.

5. Memory:

Administration: The examiner reads a list of 5 words at a rate of one per second, giving the following instructions: "This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn't matter in what order you say them". Mark a check in the allocated space for each word the subject produces on this first trial. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, read the list a second time with the following instructions: "I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time." Put a check in the allocated space for each word the subject recalls after the second trial.

At the end of the second trial, inform the subject that (s)he will be asked to recall these words again by saying, "I will ask you to recall those words again at the end of the test."

Scoring: No points are given for Trials One and Two.

6. Attention:

Forward Digit Span: Administration: Give the following instruction: "I am going to say some numbers and when I am through, repeat them to me exactly as I said them". Read the five number sequence at a rate of one digit per second.

Backward Digit Span: Administration: Give the following instruction: "Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order." Read the three number sequence at a rate of one digit per second.

Scoring: Allocate one point for each sequence correctly repeated, (N.B.: the correct response for the backwards trial is 2-4-7).

Vigilance: Administration: The examiner reads the list of letters at a rate of one per second, after giving the following instruction: "I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand".

Scoring: Give one point if there is zero to one errors (an error is a tap on a wrong letter or a failure to tap on letter A).

Box 10: Montreal Cognitive Assessment Instructions Continued

Serial 7s: Administration: The examiner gives the following instruction: “Now, I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop.” Give this instruction twice if necessary.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correct subtraction, 2 points for two-to-three correct subtractions, and 3 points if the participant successfully makes four or five correct subtractions. Count each correct subtraction of 7 beginning at 100. Each subtraction is evaluated independently; that is, if the participant responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction. For example, a participant may respond “92 – 85 – 78 – 71 – 64” where the “92” is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the item would be given a score of 3.

7. Sentence repetition:

Administration: The examiner gives the following instructions: “I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]: ***I only know that John is the one to help today.***” Following the response, say: “Now I am going to read you another sentence. Repeat it after me, exactly as I say it [pause]: ***The cat always hid under the couch when dogs were in the room.***”

Scoring: Allocate 1 point for each sentence correctly repeated. Repetition must be exact. Be alert for errors that are omissions (e.g., omitting “only”, “always”) and substitutions/additions (e.g., “John is the one who helped today;” substituting “hides” for “hid”, altering plurals, etc.).

8. Verbal fluency:

Administration: The examiner gives the following instruction: “Tell me as many words as you can think of that begin with a certain letter of the alphabet that I will tell you in a moment. You can say any kind of word you want, except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix, for example, love, lover, loving. I will tell you to stop after one minute. Are you ready? [Pause] Now, tell me as many words as you can think of that begin with the letter F. [time for 60 sec]. Stop.”

Scoring: Allocate one point if the subject generates 11 words or more in 60 sec. Record the subject’s response in the bottom or side margins.

9. Abstraction:

Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example: “Tell me how an orange and a banana are alike”. If the subject answers in a concrete manner, then say only one additional time: “Tell me another way in which those items are alike”. If the subject does not give the appropriate response (fruit), say, “Yes, and they are also both fruit.” Do not give any additional instructions or clarification. After the practice trial, say: “Now, tell me how a train and a bicycle are alike”. Following the response, administer the second trial, saying: “Now tell me how a ruler and a watch are alike”. Do not give any additional instructions or prompts.

Box 10: Montreal Cognitive Assessment Instructions Continued

Scoring: Only the last two item pairs are scored. Give 1 point to each item pair correctly answered. The following responses are acceptable:

Train-bicycle = means of transportation, means of travelling, you take trips in both;

Ruler-watch = measuring instruments, used to measure.

The following responses are not acceptable: Train-bicycle = they have wheels; Ruler-watch = they have numbers.

10. Delayed recall:

Administration: The examiner gives the following instruction: "I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember." Make a check mark (✓) for each of the words correctly recalled spontaneously without any cues, in the allocated space.

Scoring: Allocate 1 point for each word recalled freely without any cues.

Optional:

Following the delayed free recall trial, prompt the subject with the semantic category cue provided below for any word not recalled. Make a check mark (✓) in the allocated space if the subject remembered the word with the help of a category or multiple-choice cue. Prompt all non-recalled words in this manner. If the subject does not recall the word after the category cue, give him/her a multiple choice trial, using the following example instruction, "Which of the following words do you think it was, NOSE, FACE, or HAND?"

Use the following category and/or multiple-choice cues for each word, when appropriate:

FACE: category cue: part of the body

multiple choice: nose, face, hand

VELVET: category cue: type of fabric

multiple choice: denim, cotton, velvet

CHURCH: category cue: type of building

multiple choice: church, school, hospital

DAISY: category cue: type of flower

multiple choice: rose, daisy, tulip

RED: category cue: a colour

multiple choice: red, blue, green

Scoring: No points are allocated for words recalled with a cue. A cue is used for clinical information purposes only and can give the test interpreter additional information about the type of memory disorder. For memory deficits due to retrieval failures, performance can be improved with a cue. For memory deficits due to encoding failures, performance does not improve with a cue.

11. Orientation:

Administration: The examiner gives the following instructions: "Tell me the date today". If the subject does not give a complete answer, then prompt accordingly by saying: "Tell me the [year, month, exact date, and day of the week]." Then say: "Now, tell me the name of this place, and which city it is in."

Scoring: Give one point for each item correctly answered. The subject must tell the exact date and the exact place (name of hospital, clinic, office). No points are allocated if subject makes an error of one day for the day and date.

TOTAL SCORE: Sum all subscores listed on the right-hand side. Add one point for an individual who has 12 years or fewer of formal education, for a possible maximum of 30 points. A final total score of 26 and above is considered normal.

Box 11: 6 Item Cognitive Impairment Test (6CIT)

The 6CIT Dementia Test

How the test works

Question	Score range	Weighting	Weighted score
What Year is it	0-1	x4	
What month is it	0-1	x3	
Give the memory phrase <i>e.g.</i> <i>(John/Smith/42/West Street/Bedford)</i>			
About what time is it	0-1	x3	
Count back from 20-1	0-2	x2	
Say months in reverse	0-2	x2	
Repeat the memory phrase	0-5	x2	
Total score for 6CIT	0-28		

0-7 = normal - referral not necessary at present

8- 9 = mild cognitive impairment - probably refer

10-28 = significant cognitive impairment - refer

Box 11: 6 Item Cognitive Impairment Test (6CIT) Instructions

Advanced Information

How to perform and score the test

Try to perform the test in a quiet place with no obvious clock or calendar visible to the patient.

Ask the patient what year it is?

- If they get it correct then they score zero (no errors), if they get it wrong then score 1

What month is it?

- If correct score zero and if wrong then score 1

Tell the patient that you are going to tell them a fictional address which you would like them to try and memorise and then repeat back to you afterwards.

- Say "John / Brown / 42 / West Street / Bedford" (or devise a similar address relevant to your country with 5 main elements (eg. Richard Buerks 42 Sandton Road Durban might be more relevant for South Africa). Make sure that the patient is able to repeat the address correctly before moving on and warn them to try and memorise it as you are going to ask them to repeat it again in a few minutes. No score is made at this stage.

Ask the patient the time

- If they get to within 60 minutes or an hour of the correct time then they score zero, if not score 1

Ask the patient to count backwards from 20 to 1.

- If they do this correctly they score zero, if they make one error then score 1 and for 2 or more errors score 2 (note they can not score more than 2 for this question).

Ask the patient to say the months of the year backwards starting at December.

- I tend to give them plenty of time for this and it doesn't matter if they have to keep saying the months of the year forwards in order to get the answer. Inevitably they sometimes forget where they were, and I sometimes prompt them or offer encouragement that they're doing well. Again if they get it all correct then score zero, one error – score one, 2 or more errors score 2.

Finally ask them to repeat the address back to you.

- The address is broken into 5 segments and is scored for each error they make in remembering it up to a score of 5. I.e. All correct = zero, one bit wrong = 1, 2 parts wrong = 2, 3 parts wrong = 3, 4 parts wrong = 4 and all wrong = 5 Finally to complete the scoring multiply the score for each question by the weight in the neighbouring column and then add up all the weighted scores which should give you a score of between 0 – 28.

- 0-7 probably normal
- 8-9 mild cognitive impairment
- 10 + probably significant moderate to severe cognitive impairment

I hope this answers any queries you may have, I suggest you try out the test on a couple of fit volunteers first so you can get the hang of it. It is not as complicated as the above instructions make it look. If you get stuck please feel free to email me for advice.

To access more cognitive assessment tools, visit: <http://www.primarycareforms.com/>

Box 12: Other Cognitive Assessment Tools

Canadian Medical Association recommendations for the diagnosis of dementia:

Brief cognitive tests

- A range of brief cognitive tests, including the Montréal Cognitive Assessment,² the DemTect,³ the 7-Minute Screen,⁴ the General Practitioner Assessment of Cognition⁵ and the Behavioural Neurology Assessment Short Form,⁶ may be more accurate than the Mini-Mental State Examination in discriminating between dementia and the normal state. There is insufficient evidence to recommend one test over the others [grade B recommendation, level 2 evidence; new recommendation].
- Brief cognitive tests have not been developed to differentiate between dementia subtypes and should not be used for this purpose [grade D recommendation, level 2 evidence; new recommendation].

Howard H. Feldman MD et al. CMAJ 2008;178:825-836

Box 13: Katz Index of Independence in Activities of Daily Living

Patient Name: _____

Date: _____

Patient ID # _____

Katz Index of Independence in Activities of Daily Living		
Activities Points (1 or 0)	Independence (1 Point)	Dependence (0 Points)
	NO supervision, direction or personal assistance.	WITH supervision, direction, personal assistance or total care.
BATHING Points: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.
TOTAL POINTS: _____ SCORING: 6 = High (<i>patient independent</i>) 0 = Low (<i>patient very dependent</i>)		

Source:

try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordnign.org

Box 14: Lawton Instrumental Activities of Daily Living Scale

Patient Name: _____

Date: _____

Patient ID # _____

LAWTON - BRODY INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)			
Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).			
A. Ability to Use Telephone		E. Laundry	
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
2. Dials a few well-known numbers	1	2. Launders small items-rinses stockings, etc.	1
3. Answers telephone but does not dial	1	3. All laundry must be done by others	0
4. Does not use telephone at all	0		
B. Shopping		F. Mode of Transportation	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation		G. Responsibility for Own Medications	
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
D. Housekeeping		H. Ability to Handle Finances	
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		
Score		Score	
		Total score _____	
A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.			

Source: *try this*: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

Box 15: Neuropsychological Testing

Canadian Medical Association recommendations for the diagnosis of dementia:

Neuropsychological testing

- The diagnosis and differential diagnosis of dementia is currently a clinically integrative one. Neuropsychological testing alone cannot be used for this purpose and should be used selectively in clinical settings [grade B recommendation, level 2 evidence; new recommendation].
- Neuropsychological testing may aid in:
 - addressing the distinction between normal aging, mild cognitive impairment or cognitive impairment without dementia, and early dementia [grade B recommendation, level 2 evidence; new recommendation];
 - addressing the risk of progression from mild cognitive impairment or cognitive impairment without dementia to dementia or Alzheimer disease [grade B recommendation, level 2 evidence; new recommendation]; and
 - determining the differential diagnosis of dementia and other syndromes of cognitive impairment [grade B recommendation, level 2 evidence; new recommendation].

Howard H. Feldman MD et al. CMAJ 2008;178:825-836

Box 16: Structural Neuroimaging

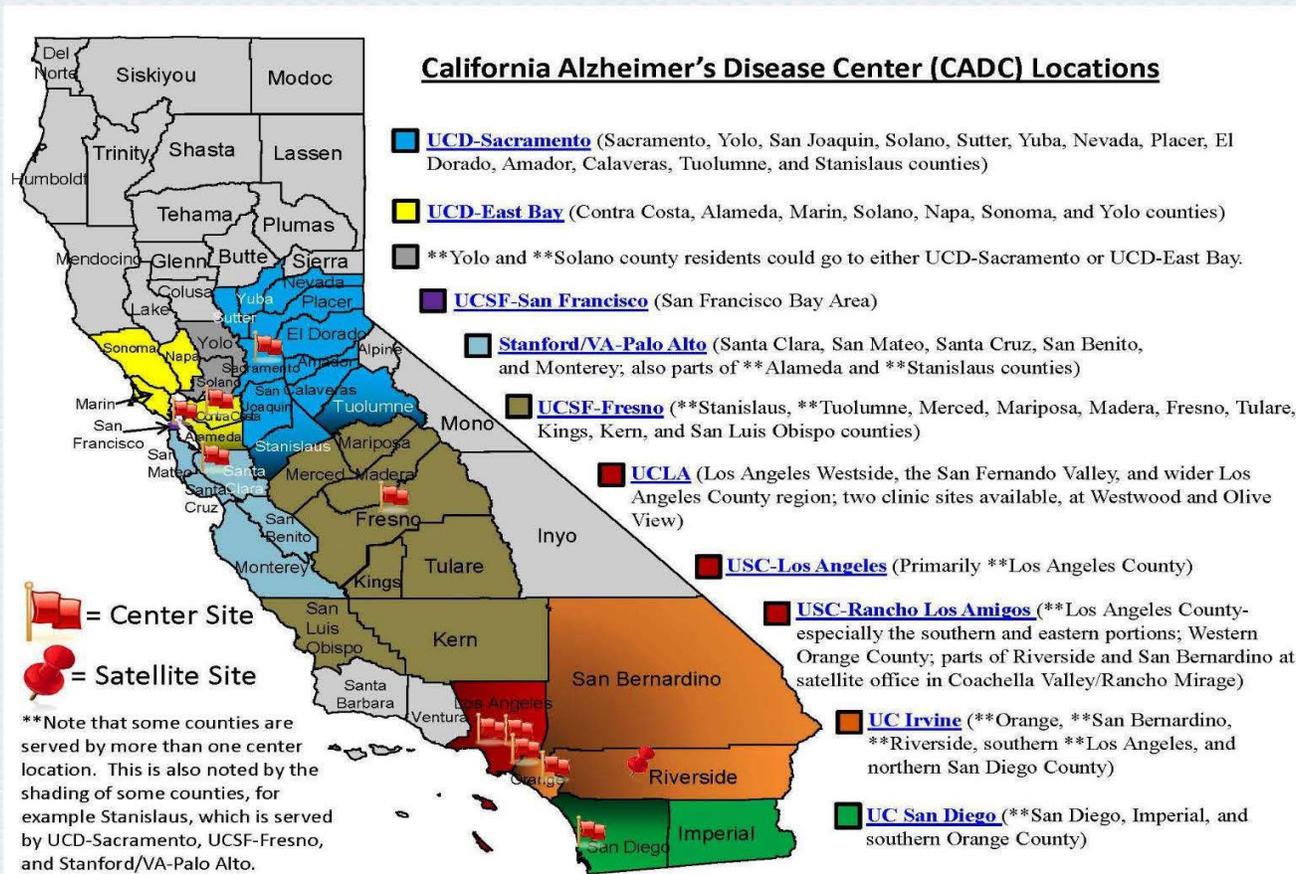
Canadian Medical Association recommendations for the diagnosis of dementia:

Neuroimaging with computed tomography and magnetic resonance imaging

- Cranial computed tomography scanning is recommended if one or more of the following criteria are present [grade B recommendation, level 3 evidence; recommendation unchanged]:
 - Age < 60 years
 - Rapid (e.g., over 1-2 months) unexplained decline in cognition or function
 - Short duration of dementia (< 2 years)
 - Recent and significant head trauma
 - Unexplained neurologic symptoms (e.g., new onset of severe headache or seizures)
 - History of cancer (especially types that metastasize to the brain)
 - Use of anticoagulants or history of bleeding disorder
 - History of urinary incontinence and gait disorder early in the course of dementia (as may be found in normal pressure hydrocephalus)
 - Any new localizing sign (e.g., hemiparesis or a Babinski reflex)
 - Unusual or atypical cognitive symptoms or presentation (e.g., progressive aphasia)
 - Gait disturbance
- There is fair evidence to support the use of structural neuroimaging with computed tomography or magnetic resonance imaging to rule in concomitant cerebrovascular disease that can affect patient management [grade B recommendation, level 2 evidence; new recommendation].

Howard H. Feldman MD et al. CMAJ 2008;178:825-836

Box 17: California Alzheimer's Disease Centers (CADCs)



California Alzheimer's Disease Center (ADC) Locations

- **UCD-Sacramento** (Sacramento, Yolo, San Joaquin, Solano, Sutter, Yuba, Nevada, Placer, El Dorado, Amador, Calaveras, Tuolumne, and Stanislaus counties)
- **UCD-East Bay** (Contra Costa, Alameda, Marin, Solano, Napa, Sonoma, and Yolo counties)
- ****Yolo and **Solano county residents could go to either UCD-Sacramento or UCD-East Bay.**
- **UCSF-San Francisco** (San Francisco Bay Area)
- **Stanford/VA-Palo Alto** (Santa Clara, San Mateo, Santa Cruz, San Benito, and Monterey; also parts of **Alameda and **Stanislaus counties)
- **UCSF-Fresno** (**Stanislaus, **Tuolumne, Merced, Mariposa, Madera, Fresno, Tulare, Kings, Kern, and San Luis Obispo counties)
- **UCLA** (Los Angeles Westside, the San Fernando Valley, and wider Los Angeles County region; two clinic sites available, at Westwood and Olive View)
- **USC-Los Angeles** (Primarily **Los Angeles County)
- **USC-Rancho Los Amigos** (**Los Angeles County- especially the southern and eastern portions; Western Orange County; parts of Riverside and San Bernardino at satellite office in Coachella Valley/Rancho Mirage)
- **UC Irvine** (**Orange, **San Bernardino, **Riverside, southern **Los Angeles, and northern San Diego County)
- **UC San Diego** (**San Diego, Imperial, and southern Orange County)

■ = Center Site
● = Satellite Site

****Note that some counties are served by more than one center location. This is also noted by the shading of some counties, for example Stanislaus, which is served by UCD-Sacramento, UCSF-Fresno, and Stanford/VA-Palo Alto.**

UCD-Sacramento

Alzheimer's Disease Center
 Lawrence J. Ellison Ambulatory Care Center
 4860 Y Street, Suite 3900
 Sacramento, CA 95817
 Phone: (916) 734-5496

UCD-East Bay

Alzheimer's Disease Center
 100 North Wiget Lane, Suite 150
 Walnut Creek, CA 94598
 Phone: (855) 420-2612

UCSF-San Francisco

Memory and Aging Center
 Mission Bay Neurology
 1500 Owens Street Suite 320
 San Francisco, CA 94158
 Phone: (415) 353-2057

Stanford/VA-Palo Alto

Alzheimer's Research Center
 Department of Psychiatry (116F)
 3801 Miranda Avenue
 Palo Alto, CA 94304
 Phone: (650) 858-3915

UCSF-Fresno

Alzheimer's and Memory Center
 6137 North Thesta Street
 Fresno, CA 93710
 Phone: (559) 227-4810

UCLA

Memory Disorders Clinic
 UCLA Medical Center, Westwood
 300 Medical Plaza, Suite B-200
 Los Angeles, CA 90024
 Phone: (310) 794-6039

USC-Los Angeles

Healthcare Consultation Center II
 1520 San Pablo Street, HCT 3000
 Los Angeles, CA 90033
 Phone: (323) 442-7600

USC-Rancho Los Amigos

National Rehabilitation Center
 Geriatric Neurobehavior and Alzheimer Center
 7601 E. Imperial Hwy
 Downey, CA 90242
 Phone: (562) 401-8130

UC Irvine

Memory Assessment and Research Center
 UCI MIND Alzheimer's Disease Research Center
 1100 Gottschalk Medical Plaza
 Irvine, CA 92697-4285
 Phone: (949) 824-2382

UC San Diego

Memory, Aging and Resilience Clinic
 8950 Villa La Jolla Drive, Suite C207
 La Jolla, CA 92037
 Phone: (858) 534-8730

**UCLA (Research Appts.-Español)

Memory Disorders Clinic
 Olive View-UCLA Med. Center
 14445 Olive View Drive 2C136
 Sylmar, CA 91342-1437
 Phone: (818) 212-4597

**USC-Rancho Los Amigos

Eisenhower Medical Center
 Rancho Mirage
 1st floor 39000 Bob Hope Drive
 Rancho Mirage, CA 92270
 Phone: (760) 834-7964

** Denotes a satellite office/clinic site.

<http://www.cdph.ca.gov/programs/alzheimers/Pages/Default.aspx>



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The Alzheimer's Association. Health Care Professionals and Alzheimer's: Cognitive Assessment.
<http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp>

The General Practitioner Assessment of Cognition.
<http://gpcog.com.au/>

Primary Care Forms, Clinical Scoring Systems. 6 Item Cognitive Impairment Test.
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ACT on Alzheimer's. For Professionals.
<http://www.actonalz.org/improve-care>



Check out ACT on Alzheimer's Instructional Videos Here!
<http://www.actonalz.org/videos>

