Dementia Work-Up
Provider Checklist

Follow these diagnostic guidelines in response to patient failure on cognitive screening (e.g., Mini-cog) or other signs of possible cognitive impairment.

History and Physical
- Review onset, course, and nature of memory and cognitive deficits (Alzheimer’s Association Family Questionnaire may assist) and any associated behavioral, medical or psychosocial issues
- Assess ADLs and IADLs, including driving and possible medication and financial mismanagement
- Conduct structured mental status exam (e.g., MoCA, SLUMS, MMSE)
- Assess mental health (consider depression, anxiety, chemical dependency)
- Perform neurological exam focusing on focal/lateralizing signs, vision, including visual fields and extraocular movements, hearing, speech, gait, coordination, and evidence of involuntary or impaired movements

Diagnostics
1. Routine lab tests
   - CBC, lytes, BUN, Cr, Ca, LFTs, Glucose

2. Dementia screening labs:
   - TSH, B12

3. Contingent labs (per patient history)
   - RPR or MHA-TP, HIV, heavy metals

2. Neuroimaging
   - CT or MRI when clinically indicated

3. Neuropsychological testing
   - Indicated in cases of early or mild symptom presentation, for differential diagnosis, determination of nature and severity of cognitive functioning, and/or development of appropriate treatment plan
   - Typically maximally beneficial in the following score ranges: MoCA 19-27; SLUMS 18-27; MMSE 18-28

Diagnosis
- Mild Cognitive Impairment
  - Mild deficit in 1 cognitive function: memory, executive, visuospatial, language, attention
  - Intact ADLs and IADLs; does not meet criteria for dementia
- Alzheimer’s disease
  - Most common type of dementia (60-80% of cases)
  - Memory loss, confusion, disorientation, dysnomia, impaired judgment/behavior, apathy/depression
- Dementia with Lewy Bodies / Parkinson’s dementia
  - Second most common type of dementia (up to 30% of cases)
  - Hallmark symptoms include visual hallucinations, parkinsonism, and fluctuations in cognition
- Frontotemporal dementia
  - Third most common type of dementia primarily affecting individuals in their 50s and 60s
  - EITHER marked changes in behavior/personality OR language variant (difficulty with speech production or loss of word meaning)
- Vascular dementia
  - Relatively rare in pure form (6-10% of cases)
  - Symptoms often overlap with those of AD; frequently there is relative sparing of recognition memory

Family Meeting
- Include family care partners
- Review diagnosis and intervention checklist (attached)
- Refer to Alzheimer’s Association (800-272-3900 or www.alz.org/mnnd)

This checklist is based in part on the Minnesota Guidelines for Alzheimer’s Disease Management. To receive a copy of the Guideline, contact the Alzheimer’s Association Minnesota-North Dakota at 800-272-3900 or www.alz.org/mnnd.
Structured Mental Status Exam

1. Montreal Cognitive Assessment (MoCA)
   - Sensitivity: 90% for MCI, 100% for dementia
   - Specificity: 87%

2. St. Louis University Mental Status (SLUMS)
   - Public domain: [http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf](http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf)
   - Sensitivity: 92% for MCI, 100% for dementia
   - Specificity: 81%

3. Mini-Mental Status Exam (MMSE)
   - Sensitivity: 18% for MCI, 78% for dementia
   - Specificity: 100%
   - Note: This instrument is **not a preferred tool** in memory loss assessment. Accumulating evidence shows it is significantly less sensitive than both the MoCA and SLUMS in identifying MCI and early stage dementia.

References:

