Cognitive Screening and Assessment Patient Note

Service Date: _____ Service Time: _____ Reason for Consult: **Cognitive Screening/Assessment**

Requesting Physician: _____ Primary Care Physician: _____

SUBJECTIVE

HPI: Name_____ Age_____ Ethnicity_____ Sex_____
who presents for (Cognitive Concern, Positive Mini-Cog Screening, or Need for Cognitive Assessment)

Source of Information: ❑ Patient ❑ Spouse ❑ Family ❑ Friend

Respondents in Room: ❑ Yes, name_____ ❑ No
Consider receiving ancillary information from family/friends separate from patient

Family History of memory/cognitive problems or dementia: _____

Length of Cognitive Symptoms/Concern: _____

AD8 Dementia Screening Interview (Total Score Pulled in or Full AD8 Completed During Visit)

AD8 may need to be performed by patient or completed by family/friend

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:		XXXXXXX	XXXXXXX

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Mini-Cog© Cognitive Screening Results

Word Recall (0-3 Points):		**1 point** for each word spontaneously recalling without cueing
Clock Draw (0 or 2 points):		**2 points** for a normal clock or **0 (zero) points** for an abnormal clock drawing. • A normal clock must include all numbers (1-12), each only once, in the correct order and direction (clockwise) • There must also be two hands present, one pointing to the 11 and one pointing to 2 • Hand length is not scored in the Mini-Cog© algorithm
Total Score (0-5 points):		**A total score of 0, 1, or 2** indicates higher likelihood of clinically important cognitive impairment **A total score of 3, 4, or 5** indicates lower likelihood of dementia, but does not rule out some degree of cognitive impairment

Past Medical History: _____

_____

Past Surgical History: _____

_____

Social History: _____

_____

Medications: _____

_____

Current Allergies: _____

_____

Current living environment: ❑ Home ❑ Family Member Home ❑ Independent Living Facility
❑ Assisted Living Facility ❑ Skilled Nursing Facility ❑ Group Home

Which of the following is the patient independent in performing?

❑ None ❑ Bathing ❑ Dressing ❑ Grooming ❑ Toileting ❑ Feeding ❑ Transfers

❑ Other_____

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Which of the following is the patient independent in performing?

❑ None ❑ Shopping ❑ Driving ❑ Managing Medications ❑ Managing Finances ❑ Cooking

❑ Cleaning ❑ Laundry ❑ Using the Telephone ❑ Other_____

REVIEW OF SYSTEMS

Weight Change: ❑ No Significant Change ❑ Weight Gain _____lbs in _____weeks ❑ Weight Loss _____lbs in _____weeks

Appetite: ❑ Good ❑ Fair ❑ Poor ❑ Increase ❑ Decrease

Hearing: ❑ Normal Hearing ❑ Decreased Hearing ❑ Hearing Aides

Vision: ❑ Good ❑ Fair ❑ Poor ❑ Corrective Lenses ❑ Legally Blind

Have you ever fallen or recent falls? ❑ Yes, _____ falls in the past year, and _____

Mood: ❑ Agitated ❑ Angry ❑ Anxious ❑ Apathetic ❑ Calm ❑ Depressed ❑ Flat ❑ Happy ❑ Irritable ❑ Sad

❑ Other_____

Sleep: ❑ Difficulty falling asleep ❑ Difficulty staying asleep ❑ Restless legs ❑ Snoring ❑ Talking ❑ Witnessed Apnea

History of Drug/Alcohol Use History: ❑ Alcohol _____ ❑ Tobacco _____

Neurologic: ❑ Migraine headaches ❑ Tension headache ❑ Syncope ❑ Seizures ❑ Numbness or tingling of hands

❑ Numbness or tingling of feet ❑ Tremor ❑ Confusion ❑ SEE HPI

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OBJECTIVE: Physical Exam

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself —or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
TOTAL SCORE:				

Score Interpretation:

Scores ≤4 suggest minimal depression which may not require treatment.

Scores 5-9 suggest mild depression which may require only watchful waiting and repeated PHQ-9 at follow-up.

Scores 10-14 suggest moderate depression severity; patients should have a treatment plan ranging from counseling, follow-up, and/or pharmacotherapy.

Scores 15-19 suggest moderately severe depression; patients typically should have immediate initiation of pharmacotherapy and/or psychotherapy.

Scores 20 and greater suggest severe depression; patients typically should have immediate initiation of pharmacotherapy and expedited referral to a mental health specialist.

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Montreal Cognitive Assessment (MoCA)

Performed by: _____ Performed by: _____

Total MoCA Score: _____

Score of 26 or above considered normal
18-25 =mild cognitive impairment, 10-17 = moderate cognitive impairment, <10 = severe cognitive impairment

DATA:

Diagnostic tests reviewed for today's visit:

_____

_____

ASSESSMENT & PLAN:

Diagnosis:

_____

_____

Plan:

_____

_____

Any additional labs for cognitive evaluation? _____

Any recommended imaging for cognitive evaluation? _____

Dose patient require consult to Geriatrics or Brain Health? ❑ Yes ❑ No

Signature: _____ **Patient Name:** _____

Date: _____ **MRN:** _____

Time: _____