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Dementia

14 essentials of assessment and care planning

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Many GPs report a lack of time and confidence in diagnosing dementia. Fourteen practical points are described to guide the assessment and care of patients with cognitive decline.

Key points

- **Signs of possible dementia should be taken seriously; timely diagnosis is important to allow patients to be treated and patients and families to prepare for the future.**
- **Take a detailed history and perform a standardised test of cognition and a mental and physical examination.**
- **Diagnose the dementia cause; investigate for reversible causes and rule out other diagnoses, such as delirium, depression and drug adverse effects.**
- **For patients with dementia, discuss key issues including daily living, legal and financial affairs, the transition from work and driving, and the stress on supporting carers and family.**
- **Assessment should culminate in a care plan, with strategies to manage specific symptoms, support for the patient and family, regular monitoring and referrals to support groups and organisations.**
- **As symptoms and challenges change over the course of dementia, the care plan needs regular review.**

Dementia, also known as major neurocognitive disorder, is defined by decline in one or more areas of cognition leading to functional impairment in everyday life. It is usually progressive and irreversible and can result from many different causes – often in combination– of which Alzheimer's disease is the most common. Dementia becomes increasingly common with age, affecting more than 5% of people over the age of 65 years and 20% over 80.[1] However, the diagnosis is often missed in primary care, with about 50% of cases remaining undiagnosed.[2]

There are many reasons for underdiagnosis of dementia. These include uncertainty or nihilism about the diagnosis, lack of confidence or knowledge, the misperception that nothing can be done, anxiety at handling the emotional distress of patients, failure to consult an informant because of concerns about patient confidentiality, and time pressure.[3,4]

We present 14 practical and efficient points to assist clinicians in primary care assess a person for cognitive decline and plan their care. These points are summarised in the box on page 20. The ongoing management of patients with dementia will be discussed in a future issue.

THE FOURTEEN ESSENTIALS

1. When patient or family raise concerns, do not dismiss as 'old age'

Memory loss can have many causes. If patients raise concerns about their memory or other aspects of their cognition, always take this seriously, investigate its causes and monitor it over time, as it may be a sign of dementia. Timely diagnosis of dementia is very important because it allows patients and families to:

- receive treatment and support
- plan for the future
- organise their financial and legal affairs
- understand their experiences
- maximise the safety of themselves and others by making the necessary preparations for driving, work and everyday living.

For all middle-aged and older patients, it is worthwhile discussing ways to reduce their risk of dementia. This might include minimising

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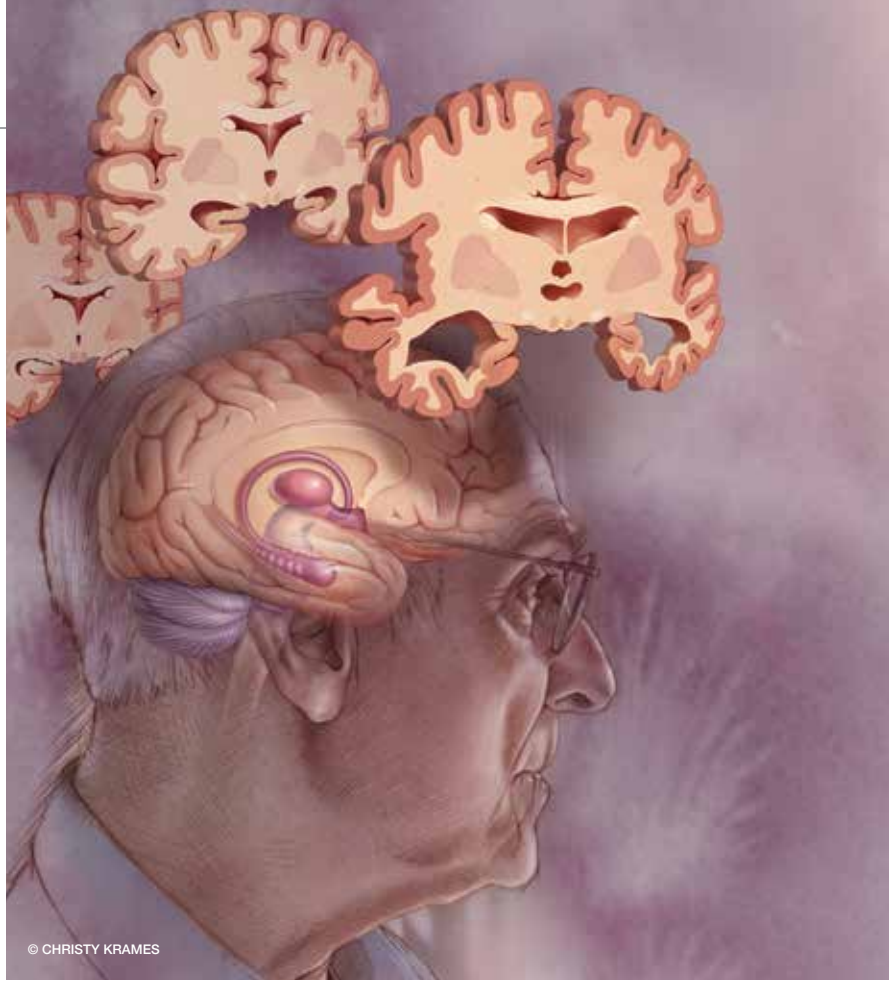

controllable risk factors, such as those associated with vascular diseases (diabetes, hypertension, hypercholesterolaemia and obesity) as well as excessive alcohol consumption and smoking.[5] For middle-aged patients, minimising hypertension has the strongest evidence. For all patients, it is important to encourage healthy behaviours, such as physical activity and exercise, a healthy diet, cognitive activity, social engagement and avoidance of head injuries (e.g. wearing a helmet while cycling and avoiding risky climbing and body contact sports).

2. Be alert to cognitive decline in older patients especially those aged 75 plus, routinely ask about difficulties

If cognitive decline is suspected, ask patients about this directly rather than avoiding the issue. An easy way of starting the conversation is simply to ask: 'How is your memory?' and 'Do you think your memory has changed?' Common signs of dementia include:

- memory loss and forgetfulness (e.g. forgetting conversations, losing items, repeating oneself, forgetting medications or appointments)
- difficulty performing familiar tasks and activities (e.g. managing finances, uncharacteristically forgetting to pay bills)
- language difficulties (e.g. problems in word-finding, richness of language)
- disorientation to time and place
- impaired judgement and decision making
- problems with abstract thinking and planning
- loss of initiative, less interest in hobbies.

These symptoms usually indicate cognitive impairment, which may result from a number of conditions (see Points 6 and 7, below). Other symptoms such as changes in mood, behaviour or personality can also occur. Patients with dementia can have some symptoms but not others (e.g. not all patients with dementia have memory problems). Family members often notice changes before patients complain.

A number of risk factors are associated with an increased likelihood of developing dementia and increase the relevance of periodically checking for signs of cognitive decline. These include general risk factors such as older age, family history of dementia and intellectual disability (especially Down syndrome) the vascular risk factors discussed above (e.g. hypertension, hyperlipidaemia or obesity in mid-life, diabetes, smoking, excessive alcohol consumption and high homocysteine levels) and neurological and neuropsychiatric risk factors (e.g. a history of stroke, depression, Parkinson's disease and head injury with loss of consciousness).[6-8]

There is debate about the value of cognitive screening of asymptomatic patients because of the possibility of false positive and false negative results. However, patients with concerns about their cognition should always have a cognitive assessment. Cognitive assessment is just a step towards diagnosis; an abnormal result on a short test does not equate to a diagnosis.

3. Take history regarding cognition and function from informant

For all patients with possible dementia, take a comprehensive clinical history. This should cover the following areas.

- Onset. How did it start – suddenly (such as with a stroke) or gradually?
- Progression. How has it progressed – gradually as in Alzheimer's disease or stepwise as in multi-infarct dementia? Has there been any progression in the past six months?
- Current cognitive symptoms and their impact on everyday functioning. Are these subtle (e.g. difficulty learning to operate a new electronic device or managing finances), intermediate (e.g. mistakes with cooking) or basic (e.g. becoming confused with dressing)?
- Other illnesses. This includes past and current

14 ESSENTIALS FOR GOOD DEMENTIA CARE IN GENERAL PRACTICE

1. When patient or family raise concerns about memory/cognition, do not dismiss as 'old age'
2. Be alert to cognitive decline in older patients especially those aged 75 plus – routinely ask about difficulties
3. Take history regarding cognition and function from informant
   a. Clinical history – onset, progression, medications, other illnesses, behavioural and psychological symptoms
   b. Interview informant (separately where possible), assess carer needs
   c. Activities of daily living (ADL), instrumental ADLs, mood, driving, safety
4. Assess cognition if any indication or suspicion of impairment
   a. Mini Mental State Examination (MMSE) and clock drawing test, General Practitioner Assessment of Cognition (GPCOG) or Rowland Universal Dementia Assessment Scale (RUDAS), for culturally and linguistically diverse groups
   b. If uncertain, repeat over time
5. Conduct mental state and physical examination
   a. Look for specific conditions that mimic dementia (depression, delirium, drugs) or that can aggravate dementia (e.g. cardiac failure, use of anticholinergic drugs)
   b. Check nutrition, hygiene, visual or hearing impairment
6. Investigate for causes of cognitive decline
   a. Rule out rare but reversible causes (e.g. abnormal thyroid function, hypercalcaemia, vitamin B_{12} deficiency, tumour)
7. Diagnose cause – exclude depression and delirium, diagnose type of dementia
   a. Type of dementia – 90% Alzheimer's, vascular or mixed dementia; then Lewy body and frontotemporal dementia
8. Refer to specialist if unsure of diagnosis; patient is young or atypical; symptoms and signs are atypical; psychotic or severe behavioural disturbance occur; multiple, complex comorbidities exist; or considering medication
9. Inform patient and family of diagnosis, management plan and prognosis
10. Discuss key issues with patient and family
    a. Legal issues – enduring power of attorney, enduring guardianship, advance care planning, driving and work (particularly for licensed machinery operators)
    b. Medication for Alzheimer's disease if appropriate
    c. Lifestyle – regular exercise, mental stimulation, establish routine
    d. General health – blood pressure, other health conditions
11. Develop care plan (include legal/financial matters) and make follow-up appointments
12. Refer patient and family for further information and support to Alzheimer's Australia (phone 1800 100 500 National Dementia Help Line) and to community services
13. Manage physical and psychological comorbidities and maintain optimal health, be alert to delirium
14. Regularly review care plan

medical and psychiatric history (particularly with respect to risk factors for dementia and conditions such as depression, stroke, acute myocardial infarction and hypertension). It also includes, where relevant, the patient's sexual history, specifically risk of syphilis and HIV infection
- Medications (including illicit and over-the-counter) and any possible side effects (e.g. confusion)
- Behavioural and psychological symptoms, including personality change
- Diet, exercise, healthy activities, alcohol consumption and smoking
- Family and social support.

With the patient's permission, interview an informant such as a family member, if available. A clinical history from an informant is important because patients with dementia may not have insight into their deficits. It also allows the clinician to determine the patient's premorbid functioning. Ideally, the informant should be interviewed separately as they may feel uncomfortable talking openly in the patient's presence. Some assessment of the informant's physical and mental health is also important.

4. Assess cognition if any indication or suspicion of impairment

Use a standardised test to accurately detect cognitive impairment and enable any decline to be assessed over time. Suitable tests are available at the Dementia Outcomes Measurement Suite website (http://www.dementia-assessment.com.au). Those recommended for use in primary care include:
- the Mini-Mental State Examination (MMSE) combined with the clock drawing test. Together these tests take 10 to 15 minutes to administer
- the General Practitioner Assessment of Cognition (GPCOG). This short test was developed specifically for use in Australian primary care.[9] It has two parts: a cognitive test for the patient that takes less than four minutes to administer and includes the clock drawing test; and a short interview

with an informant. It is available free at the GPCOG website (http://www.gpcog.com.au
- Kimberley Indigenous Cognitive Assessment (KICA-Cog) for Indigenous Australians in remote areas.
- Rowland Universal Dementia Assessment Scale (RUDAS) for people from culturally and linguistically diverse backgrounds.

Patients from culturally and linguistically diverse backgrounds should ideally be assessed in their primary language. For all patients, record their responses to all test items, not just the final score, as these will be useful to assess changes over time. All test results should be interpreted cautiously, taking into account other factors that might impair test performance (e.g. anxiety, depression, dysphasia, English as a second language, lack of education, sensory impairment) and factors that might compensate for decreased cognition (e.g. high level of education and intellect). Short tests may not be sensitive to mild impairment or for people of higher intellectual capacities (false negative) and may falsely suggest impairment for people with lifelong lesser intellectual capacities (false positive).

If the results are unclear, repeat the test over time or consider referral for more extensive neuropsychological testing. Reassessment after six to 12 months is usually recommended, and decline over time may be a more significant indicator than one poor score. Patients who show evidence and complain of cognitive decline but who have no significant functional impairment in daily life are referred to as having 'mild cognitive impairment'. These patients are at higher risk of developing dementia, but some revert to normal. They should be monitored and referred for further cognitive assessment if there are concerns.

5. Conduct mental state and physical examination

A complete and thorough clinical examination is necessary. In particular, look for conditions that:

- mimic dementia (e.g. depression, delirium, drug effects)
- cause dementia (e.g. vitamin B_{12} or folate deficiency, hypercalcaemia, thyroid deficiency, neoplasm)
- impair cognition (e.g. anaemia, anticholinergic medication, cardiac failure, hyponatraemia, pain, psychoactive medication, renal failure)
- cause delirium (e.g. drugs, infection, metabolic abnormalities).

Assess the patient's nutrition, hygiene and oral health. Check for any visual or hearing impairments, and correct these if possible. Note all medical and psychiatric comorbidities and ensure that they continue to be managed optimally. It is also important to take a full drug history, including over-the-counter products, as many drugs can impair cognition. Problems can arise when doses are changed, when a new drug is added, or when a previously taken drug is stopped. A home medicines review undertaken by a pharmacist in close collaboration with the GP can be useful, especially if the GP indicates that this is to check for medications that can impair cognition.

6. Investigate for causes of cognitive decline

There are many causes of cognitive decline, and some are potentially reversible. These can be neurological conditions (e.g. subdural haematoma, cerebral tumour), infectious or inflammatory diseases (e.g. encephalitis, meningitis) and metabolic or endocrine disorders (e.g. hypothyroidism, vitamin B_{12} deficiency).

The following investigations should be performed for all patients with possible dementia to rule out treatable causes:

- blood tests – haemoglobin concentration; white cell count; levels of C-reactive protein, urea, electrolytes, creatinine, calcium, magnesium and phosphate; liver function; fasting blood glucose level; thyroid function; serum B_{12} and folate levels
- urine tests – white blood cells, protein and glucose levels, urinalysis and (if a urinary tract infection is suspected) culture and sensitivity
- structural neuroimaging – noncontrast CT scan of the brain.

Other investigations that should be performed if specifically indicated include:

- chest x-ray
- electrocardiography or Holter monitoring
- echocardiography
- syphilis serology
- HIV testing.

Investigations that can be performed if indicated and are usually ordered by a specialist include:

- MRI scan (or a positron emission tomography scan)
- neuropsychological assessment
- genetic testing (e.g. for the apolipoprotein E ε4 allele, which is associated with Alzheimer's disease)
- heavy metal assays
- Lyme disease titre.

Some clinicians also investigate fasting homocysteine and vitamin D levels and iron studies.

7. Diagnose cause – exclude depression and delirium, diagnose type of dementia

Diagnose the cause of cognitive decline. Depression and delirium (a confused state precipitated by an underlying organic cause that can last for hours or months) can each lead to cognitive and functional deficits. As both are also common comorbidities of dementia, consider whether there is underlying dementia. This may become clear only when the delirium or depression resolves. Many drugs, whether prescription, over-the-counter or illicit, can cause or aggravate cognitive impairment. In particular, note the anticholinergic side effects of many commonly used medications (e.g. many antihistamines, tricyclic antidepressants and antipsychotics).

After causes for cognitive decline other than dementia have been excluded, diagnose the type of dementia. This can be important for management, particularly with regard to medication. Different types of dementia can often be distinguished on the basis of the patient's history and

TABLE 1. COMMON TYPES OF DEMENTIA[10]

Dementia type	Prevalence*	Common signs for diagnosis†
Alzheimer's disease	40 to 60%	• Progressive decline in memory and other areas of cognition (e.g. language, motor skills, recognition, planning). Atypical presentations also occur.
Vascular dementia	10 to 20%	• Rapid onset with focal neurological deficits (slow onset also possible) • Relative preservation of personality and verbal memory • Presence of vascular risk factors (e.g. hypertension, hypercholesterolaemia, diabetes) or systemic vascular disease
Mixed dementia	>15%	• Combination of Alzheimer's disease and vascular dementia‡
Dementia with Lewy bodies	<20%§	• Fluctuating impaired cognition • Visual hallucinations • Extrapyramidal features such as a Parkinsonian appearance • Sensitivity to neuroleptics • Repeated unexplained falls • REM sleep behaviour disorder
Frontotemporal dementia	≤5%	• Early onset (more common than for Alzheimer's disease) • Behavioural changes, including disinhibition, impulsiveness, lack of tact, jocularity and repetitiveness • Language changes, including difficulty in finding words, speaking fluently and comprehension • Other symptoms include decreased executive function, compulsive or stereotyped eating and hypersexuality • Memory relatively preserved in early stages
Parkinson's disease dementia	<4%	• Presence of Parkinson's disease preceding cognitive decline and absence of other causes
Alcohol-related dementia	<2%	• History of excessive alcohol consumption
Traumatic brain injury	<2%	• Head injury • Symptoms may remain stable or even improve over time

* Rates are influenced by many factors, such as the sample on which autopsies were conducted.
† All signs need not be present for a diagnosis. The dominant pathology is described, but in late life more than one pathology is often present.
‡ Although the combination of Alzheimer's disease and vascular dementia is the most common form of mixed dementia, other combinations of pathologies occur and become more frequent with age.
§ Many studies and clinicians report much lower rates.

symptoms. The most common causes of dementia and some possible indicators are shown in Table 1.[10]

8. When to refer to a specialist

Most patients with early dementia can be managed successfully in general practice. However, in certain circumstances patients may need to be referred to a specialist, such as a geriatrician, memory disorders clinic, neurologist, psychogeriatrician or psychiatrist with a special interest in dementia. These circumstances include when:

- the diagnosis is uncertain
- the patient is young or presentation is atypical
- symptoms and signs are atypical
- deterioration is rapid
- challenging psychiatric or physical comorbidities occur (especially depression)
- the patient or family is in denial or requests a second opinion
- symptoms are causing severe distress to the patient or carer
- there has been possible industrial exposure to heavy metals
- the patient has learning difficulties or Down syndrome
- an authority is needed to prescribe medications for Alzheimer's disease. The PBS currently requires confirmation of an Alzheimer's diagnosis in consultation with a specialist or consultant physician. Doctors, especially those in rural areas, can communicate with a specialist by telephone or electronically to obtain confirmation
- there are medicolegal indications.

9. Inform patient and family of diagnosis, management plan and prognosis

Unless the patient and their family specifically request otherwise, they have the right to be informed of the diagnosis so that they will know what to expect and can begin making the necessary arrangements. If patients with dementia are still legally competent, their permission must be sought for the GP to talk to their family

(currently a Medicare rebate is not available for GPs to talk to the family without the patient). When disclosing the diagnosis, it can be helpful to find out what they already know about dementia in order to reinforce accurate knowledge and to correct misconceptions. GPs need to balance confidentiality and the patient's autonomy on the one hand with beneficence and the best interests of the patient on the other. Provide patients and their family with information about dementia. Handouts, such as those from Alzheimer's Australia, and internet links can be helpful.

Most patients and their families want to be informed of the management plan and prognosis. Most dementia is progressive, but rates of decline vary considerably between individuals. On average, the time from disease onset to diagnosis is about two to three years. The time from onset to death varies from months to many years depending on the patient's age, type of dementia, and comorbidities. It is usually within 10 years from the onset of symptoms. In Alzheimer's disease, medications are available that may temporarily stabilise or slow the cognitive decline. The effects of these medications are modest; they are not cures.

In addition to cognitive decline, almost all patients with dementia experience behavioural and psychological symptoms at some point during the course of the illness. These should also be discussed. Symptoms vary and include:

- mood disturbances (e.g. anxiety, apathy, depression, euphoria)
- hyperactivity-type symptoms (e.g. aberrant motor behaviour, aggression, agitation, disinhibition, irritability)
- psychotic symptoms (e.g. delusions, hallucinations)
- other noncognitive symptoms (e.g. abnormal eating patterns, hoarding, sleep disturbances, wandering).

Behavioural and psychological symptoms often cause great stress to patients and their carers.

10. Discuss key issues with patient and family

Dementia has many consequences for patients and their families which are best discussed as early as practicable.

Legal and financial issues

Legal and financial issues include wills, enduring power of attorney, enduring guardianship (or equivalent), and advance care planning (specific requirements and terminology vary across states and territories). Family members, particularly spouses, need to address these same issues for themselves; problems can arise if the healthy family member dies first.

Financial assistance

Financial assistance may be available to both the patient (e.g. superannuation can be accessed on medical grounds) and their carer (e.g. carer's allowance or payment).

Work

If the patient is still working, decisions about continuation depend on the severity of impairment and type of work. Occupations that involve the safety of others (e.g. machine operators, pilots) require immediate cessation. Others may be able to transition from work gradually, change duties and have greater supervision.

Driving

All patients with dementia will eventually need to stop driving, some immediately. It is important to prepare patients for this early on and arrange for on-road testing if unsure. No one with diagnosed dementia can hold an unconditional driver's licence. A conditional licence may be considered by the driving licensing authority subject to annual review. This licence may involve a restriction to drive within a specified kilometre radius from their home.

All drivers in Australia with a condition that could impact on their ability to drive are legally required to inform their state licensing authority and insurance company. In South Australia and the Northern Territory, it is mandatory for GPs to report drivers with dementia. In other states and territories, discretionary reporting applies (patients who present a safety risk to themselves or others need to be reported). Transition to nondriving includes increased use of public transport, taxi subsidisation schemes and community transport options.

Daily activities and tasks

As dementia progresses, patients become increasingly dependent on others. An occupational therapist may be able to suggest ways to compensate for deficits and changes to the home environment. If extra help is needed, refer the patient to aged care services.

Carers

Carers are often referred to as 'the second patient'. Looking after individuals with dementia places high levels of stress on carers and families. As a result, carers often experience depression, poor physical health, social isolation and financial hardship. Social workers may be able to help with these issues.

11. Develop a care plan (include legal/financial matters) and make follow-up appointments

The care plan should include:

- strategies for managing specific cognitive deficits, including medications if appropriate
- strategies for managing behavioural and psychological symptoms
- strategies for managing medical and psychiatric comorbidities
- strategies for promoting general health, wellbeing and quality of life
- safety issues (e.g. driving, work, risk of falls)
- legal and financial planning
- sources of support, education and counselling for the patient and carer
- follow up.

The symptoms and rate of cognitive decline associated with dementia vary between individuals. It is important to have regular follow-up appointments.

TABLE 2. SOME HELPFUL REFERRALS FOR PATIENTS AND FAMILIES

Organisation	Website	Telephone
Alzheimer's Australia*	http://www.fightdementia.org.au	1800 100 500
Carers Australia	http://www.carersaustralia.com.au	1800 242 636
Commonwealth Respite and Carelink Centres	http://www9.health.gov.au/ccsd/	1800 052 222
Centrelink (Disability, Sickness and Carers)	http://www.humanservices.gov.au/customer/themes/carers	13 27 17
Dementia Behaviour Management Advisory Service	http://www.dbmas.org.au	1800 699 799
My Aged Care	http://www.myagedcare.gov.au	1800 200 422

* Alzheimer's Australia also provides resources for clinicians at the website http://www.detectearly.org.au.

12. Refer patient and family for further information and support to Alzheimer's Australia and to community services

Patients and families should be encouraged to contact Alzheimer's Australia, which can provide information and support for all types of dementia. 'Help sheets' from Alzheimer's Australia can be a useful resource to give to patients and their families. Other support organisations, such as Carers Australia and Commonwealth Respite and Carelink Centres, can also provide information and support (Table 2). Carers should be encouraged to participate in carer training programs as these can help improve both patients' and carers' quality of life. The Dementia Behaviour Management Advisory Service can provide support for carers who are looking after patients with behavioural and psychological symptoms of dementia.

The My Aged Care website (http://www.myagedcare.gov.au) and call centre provide information on all aged care services in Australia and are the main gateway to the aged care system. Services include assistance with bathing, shopping, cooking, cleaning and transport, as well as respite and residential care. Patients need to be assessed to gain access to services. There may be a delay before assessment, depending on how the patient is prioritised by the Aged Care Assessment Team, and a further waiting time for institution of services, so it is useful to plan ahead. Contact with local information services (e.g. the Dementia Advisory Service in NSW) may be helpful.

13. Manage comorbidities and maintain optimal health – be alert to delirium

Comorbid conditions are common in elderly patients and need to be managed. Delirium, in particular, frequently co-occurs with dementia and needs to be responded to quickly. Dementia can also exacerbate other medical conditions by reducing patients' compliance with medications. In addition to managing comorbid conditions, it is important to promote the general health of patients with dementia. General principles apply, such as ensuring adequate nutrition and exercise. Be sure to check the patient's oral health, podiatry needs, routine immunisations (e.g. influenza) and continence. In addition, assess whether the patient is in pain and consider ways to reduce the risk of falls.

14. Regularly review care plan

The symptoms and challenges associated with dementia change over its course. As a result, the care plan will need to be adjusted regularly to address the evolving picture. It is usually necessary to see patients and their carers every three to six months. In follow-up visits, it can be helpful to cover the following:

- cognitive ability and any changes
- functional ability in daily living skills and any changes (e.g. shopping, travelling, self-care)
- behavioural and psychological symptoms
- general health, including sleep, nutrition, continence, balance and mobility/gait
- medications and their effects
- psychosocial and environmental issues
- how the carer is coping with looking after the patient.

More frequent appointments may be necessary when medications are started or when challenging symptoms emerge.

PUTTING THE 14 ESSENTIALS INTO PRACTICE

In practice, following the 14 essential steps will take several consultations. A possible way of scheduling these steps over five to six consultations is shown in the box on page 27.

For patients aged 75 and over, one assessment each year is covered by the Medicare Benefits Scheme (MBS) Health Assessments items 701, 703, 705 and 707 (which apply to health assessments of varying lengths of time) and 715 (for Aboriginal and Torres Strait Islander patients). For all patients with dementia, developing a care plan is covered by the MBS Chronic Disease Management (CDM)

A POSSIBLE WAY OF SCHEDULING THE 14 ESSENTIALS OF DEMENTIA CARE

First consultation

GP becomes aware of the possibility of dementia in one of three ways:

- As a presenting problem that the patient (or interested party) raises
- Noting signs of dementia when treating other conditions
- By actively screening patients with strong risk factors for dementia

In this session:

1. Address presenting issue(s) if not dementia
2. Depending on the available time, take history, check for symptoms of dementia and/or perform cognitive testing
3. Arrange a longer consultation for more extensive testing

Second consultation

1. Take history and check for symptoms (if not already done)
2. Perform cognitive testing (if not already done)
3. Conduct a physical examination
4. For patients aged over 75 years, consider a 75-plus health assessment (may be done by a supervised nurse in a separate session)

Third consultation

1. Complete any unfinished physical assessment
2. Discuss the results from the previous consultations with the patient
3. Order relevant blood, urine and imaging tests

Fourth consultation (ideally with an informant)

1. Take a history from the informant (if available and patient gives permission)
2. Review the results of the blood, urine and imaging tests
3. Identify reversible causes and other abnormalities from the testing and treat as necessary
4. If unsure about diagnosis, refer patient to a specialist
5. If confident in diagnosis, discuss the diagnosis and prognosis with patient (and informant if present)
6. If appropriate, organise referrals for community support, pharmacy review

Fifth consultation

1. Complete GP management plan
2. Discuss key issues (e.g. legal issues, finances, driving)
3. Organise referrals for community support, pharmacy review
4. Organise subsequent appointments as necessary

Sixth consultation

1. Complete team care arrangements (if necessary)
2. Otherwise, review the patient's symptoms and how the patient and carer are coping

items 721 (GP Management Plan), 723 (Team Care Arrangements) and 732 (review of GP Management Plan and Team Care Arrangements). There is a financial advantage to both patients and GPs for using these scheduled fees for the relevant consultations instead of MBS level C and D items (long or prolonged consultations).

CONCLUSION

Following these 14 essentials will help ensure that patients with dementia receive effective and appropriate care. Management of patients with dementia, however, is complex and continuing. Clinicians in primary care need to be prepared for several years of supporting the patient, their family and caregivers. We will outline principles of ongoing management of dementia in a future issue of *Medicine Today*. MT

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A list of references is included in the website version (http://www.medicinetoday.com.au) and the iPad app version of this article.

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