

COGNITIVE TESTING

The Alzheimer Society of Haldimand Norfolk has received requests from family physicians to conduct cognitive assessments on select patients. Recognizing the challenges rural areas face in accessing timely assessment services, as well as the time constraints within primary care, the Alzheimer Society is prepared to partner with physicians to support this process.

The Alzheimer Society does not support population-based screening for memory or cognitive concerns. However, we promote early identification when there is clinical indication, as this allows individuals and their families to make informed decisions regarding care and planning while functioning at their highest possible level.

Assessment Components:

The cognitive assessment will include administration of standardized tools, including the Montreal Cognitive Assessment (MoCA), Mini-Mental State Examination (MMSE), Clock Draw Test, and Executive Function testing.

Process Requirements:

- A written referral from a physician indicating the patient is at risk for developing dementia
- Understanding that this is not a diagnostic service, but an assessment to support clinical decision-making
- Written client consent for both assessment and release of information
- Assessment completed by a trained regulated health professional

General feedback may be provided to the patient upon request; however, detailed analysis will not be discussed directly with the patient.

A written consultation report, including cognitive assessment results, will be provided to the referring physician. This report will include information to support consideration of whether the patient may be a *medically at-risk driver*.

Assessments can be completed in the client's home or at the Alzheimer Society of Haldimand Norfolk office.

Fax Referral to: 519-428-2968

Missing information will delay referral processing

Cognitive Assessment Referral Form
Haldimand Norfolk ONLY

Client Information:			
Name:		DOB:	
Address: <i>(Client must reside in Haldimand/ Norfolk only)</i>			
Telephone #:		Health Card #:	
Preferred Language:		<input type="checkbox"/> Interpreter Required:	
<input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Vision Impairment		<input type="checkbox"/> Impaired Dominate Hand <input type="checkbox"/> Other Health Related Concerns:	
Contact Preference: <i>(Who can we contact for this referral?)</i>			
<input type="checkbox"/> Client <u>Living Situation:</u> <input type="checkbox"/> Alone <input type="checkbox"/> With Family/ Caregiver		<input type="checkbox"/> Alternate Contact: Name: <u>Relationship:</u> <i>(Spouse, Child, SDM)</i> <u>Phone #:</u>	
Referring Provider:			
Physician Name:		Address:	
Fax #:	Phone #:	Signature:	Date:
Services accessed by Client:			
<input type="checkbox"/> Specialized Geriatric Services <i>(Geriatric Medicine/ Geriatric Psychiatry)</i> Specific Physician: _____		<input type="checkbox"/> Ontario Health atHome Services	
Reason for referral to: <i>(Check all that apply):</i>			
<input type="checkbox"/> Client concerned about memory loss/ impairment		<input type="checkbox"/> Other <i>(please indicate):</i>	
<input type="checkbox"/> Caregiver concerned about memory loss			
<input type="checkbox"/> Annual repeat of cognitive testing			

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