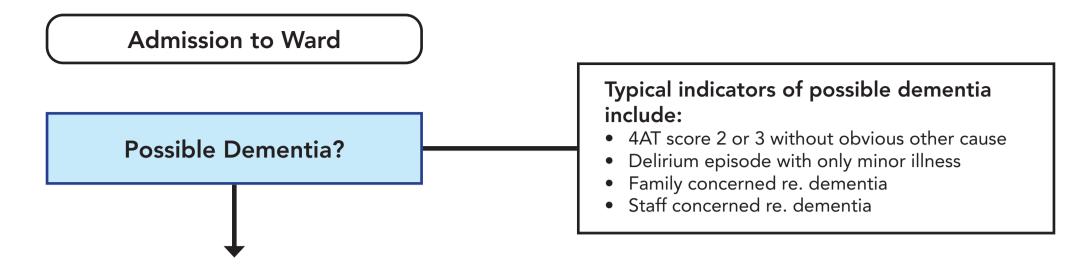
Diagnostic Pathway for Suspected Dementia on Acute Hospital Wards









Treating hospital team to complete initial dementia work-up

- Most important is to document collateral history (from family, GP, PHN)
 NB duration and course of cognitive decline; effects on functional activity
- Perform formal cognitive test (e.g. MMSE, MoCA) only if delirium is ruled out or fully resolved. In-hospital cognitive scores can be lower than usual due to illness/anxiety but can give an approximate indication of cognitive function

Primary hospital team to arrange specialist diagnostic review:

Arrange out-patient follow-up for when patient is medically well (more usual path)

- Arrange out-patient memory clinic or specialist clinic follow-up
- At discharge, inform GP of possible diagnosis and details of follow up; include whether patient and family are aware of possible diagnosis

Seek in-patient specialist review (less common path)**

Refer to CNS/ANP Dementia if available

Deciding on most appropriate service to review the patient:

- Under the age of 65: neurologist review is most appropriate usually
- Age 65 or above:
 - Geriatric medicine: if frail, medical complexity, known to service
 - Mental Health Service: if pronounced behavioral issues/psychosis; known to service
 - Neurologist: if atypical features (e.g. rapid decline, possible seizures)

CNS/ANP Dementia will indicate most appropriate service, if unsure

- ** Reasons for seeking in-patient diagnostic review include:
 - diagnosis is necessary for safe discharge
 - apparent moderate-severe dementia but no formal diagnosis
 - rapidly deteriorating cognition or atypical features
 - patient unlikely to return for out-patient review and no community in-home diagnostic service

Note: This pathway can be modified to suit local context, resources and other protocols