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Early Detection and Diagnosis of Dementia: A Practical Checklist for Primary Care Clinicians

As the number of Americans living with dementia continues to grow, and with new disease-modifying therapies emerging in the field, early and accurate detection is crucial for effective management and support. Primary care clinicians play a vital role in early detection of cognitive impairment and referral for specialized assessment and treatment.

The Alzheimer's Association expert workgroup has developed the Diagnostic Evaluation, Testing, Counseling and Disclosure of Suspected Alzheimer's Disease and Related Disorders (DETeCD-ADRD) guidance to aid clinicians in evaluating cognitive and behavioral symptoms suggested of Alzheimer's disease (AD) or Alzheimer's disease and related dementias (ADRD).

The **full guidance** is published in *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*. A **companion guidance for specialist providers** is also available.

How to Use

This checklist and decision guide uses the DETeCD-ADRD guidance to empower clinicians in any setting to make diagnoses, inform recommendations for prevention and brain health, and identify and treat comorbid medical conditions. Note, consider referral to a dementia specialist at any time if there is suspicion of early onset, atypical or rapidly progressing dementia.

The Three-Step Diagnostic Formulation: The Goal of Evaluation

The DETeCD-ADRD evaluation process does not propose dementia and Alzheimer's Disease staging criteria, which continue to evolve. Rather, it provides a rigorous framework for clinicians to establish a three-step diagnostic formulation for patient care.

STEP 1: Cognitive Functional Status

☐ **Action 1: Initial Assessment & Evaluation.** Evaluate patient presentation for cognitive-functional status. What is the patient's overall level of cognitive impairment?

The initial assessment and evaluation is a crucial step that clarifies the severity of impairment and should guide subsequent assessment and management decisions. Several validated tools are available to test a patient's level of cognitive functioning. Patient status may be classified as:

- Cognitively unimpaired
- Subjective cognitive decline (reported by patient and/or care partner)
- Mild cognitive impairment
- Mild, moderate or severe dementia

About the Workgroup & Methodology

The Alzheimer's Association convened the Diagnostic Evaluation, Testing, Counseling, and Disclosure Clinical Practice Guideline (DETeCD-ADRD CPG) Workgroup to develop guidance to help primary care clinicians and other providers to systematically evaluate, diagnose, and disclose information to patients with suspected AD or ADRD and their care partners. The workgroup involved 10 voting members representing primary care, specialty and subspecialty care, long-term and palliative care, health economics and bioethics.

About the Alzheimer's Association

The Alzheimer's Association is a worldwide voluntary health organization dedicated to Alzheimer's care, support and research. Our mission is to lead the way to end Alzheimer's and all other dementia — by accelerating global research, driving risk reduction and early detection, and maximizing quality care and support. Our vision is a world without Alzheimer's and all other dementia®. Visit alz.org or call 800.272.3900.

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- [ ] Establish shared goals for evaluation with patient and care partner; assess patient's capacity to engage in goal-setting process.
- [ ] Consider referral for comprehensive neuropsychological testing or to a dementia specialist if brief cognitive tests are insufficient, the clinical picture is complex or there are significant confounding factors.

STEP 2: Cognitive-Behavioral Syndrome

Cognitive-behavioral symptoms may include deficits or changes to memory, language, visuospatial abilities and executive function. Less typical but important symptoms may include changes to mood, motor skills and sensory problems, including hallucinations.

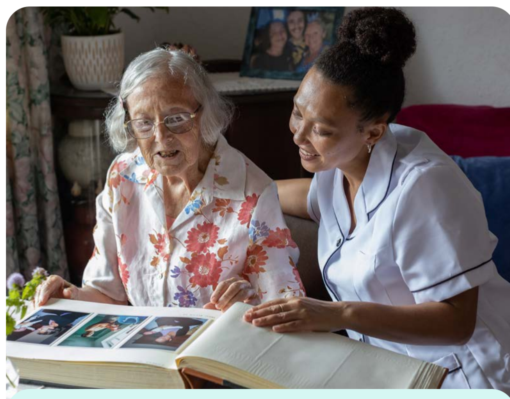
- [ ] **Action 2: Gather Clinical Information.** Assess patient's medical and psychological status by taking thorough histories and administering clinical and cognitive tests.
  - [ ] Take a detailed medical history and history of present illness from patient *and* care partner or reliable informant. Note changes in:
    - Cognitive functioning
    - Activities of daily living
    - Mood and neuropsychiatric symptoms
    - Sensory and motor function
  - [ ] Evaluate individual risk factors including:
    - Medical conditions (vascular risk, sleep apnea)
    - Age (≥65)
    - Lifestyle factors
    - Family history

Consider referral to a specialist if patient presents with early-onset cognitive decline (<65 years old) or other atypical features, such as significant attention impairments, prominent language difficulties or social-behavioral abnormalities, or cerebral-based sensory or motor dysfunction.

- [ ] Conduct mental status exams, including cognitive assessment with a validated brief cognitive test (e.g., one of the forms of the Confusion Assessment Method (CAM) to test specific aspects of mental status, or similar instrument) and dementia-focused neurologic exam. See the Alzheimer's Association's **Cognitive Assessment Tools page** for more information.

Consider referral for comprehensive neuropsychological testing or to a cognitive disorders specialist if brief cognitive tests are insufficient, the clinical picture is complex or there are significant confounding factors.

If patient has no cognitive impairment, recommend brain-healthy behaviors.



Cognitive Deficit Presentation

Initial, prominent cognitive deficits fall into several categories. According to the dementia diagnostic criteria, deficits in more than one domain should be present, along with worsening cognition by report or observation, which are important factors in diagnosis.

Amnestic:

Impairment in learning and recall of recently learned information.

Non-amnestic:

- [ ] Language presentation: Deficits in word finding.
- [ ] Visuospatial presentation: Spatial cognition including inability to recognize objects, impaired facial recognition, inability to perceive and interpret multiple objects simultaneously and loss of word comprehension (alexia).
- [ ] Executive dysfunction: Impaired reasoning, judgment and problem solving.

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STEP 3: Etiological Diagnosis

- [ ] **Action 3: Diagnostic Testing and Formulation.** Obtain laboratory tests and structural brain imaging to assess for likely brain disease(s) or condition(s) causing the symptoms.
  - [ ] Order Tier 1 laboratory tests (Blood "cognitive lab panel") including thyroid-stimulating hormone (TSH), vitamin B12, homocysteine, complete blood cell count (CBC) with differential, complete metabolic panel, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP).
  - [ ] Refer for structural brain imaging (MRI without contrast preferred; if unavailable or contraindicated, obtain non-contrast head CT).

Consider referral to a specialist for additional tests (Tier 2-4 lab tests, CSF biomarker testing, other imaging including amyloid or tau PET) if results are inconclusive.

- [ ] **Action 4: Disclosure and Care Planning.** Ensuring the patient and care partner understand the diagnosis, implications for future needs, treatments, care planning and resources are crucial for shared decision-making and goal setting that meets their individual needs.
  - [ ] Asking the patient (and documenting), "May I speak frankly about what I think is going on with your memory and thinking problems?" permits the patient to retain autonomy with disclosure.
  - [ ] Honestly and compassionately inform patient and care partner of provisional diagnosis. Discuss diagnosis, prognosis and initial treatment options, potential safety concerns and available medical, psychosocial and community support resources.
  - [ ] Work with patient and care partner to develop an initial care plan that incorporates the patient's and family's goals and preferences.
  - [ ] Identify available online and community resources for medical, psychosocial and other community support (e.g., financial, household, transportation and respite care). Helpful resources can be found **here**.
- [ ] **Action 5: Referral/Further Evaluation.** Refer patients for further evaluation and/or management if additional testing, consideration for therapy or biomarker testing, or complex case management is necessary, or if exams and tests are inconclusive.

Conclusion

The DETeCD-ADRD guidance empowers primary care clinicians to improve early detection of AD/ADRD. Dementia diagnosis and treatment is an evolving field, and this guidance will be updated as new evidence emerges.

For additional information and professional resources, visit **alz.org/ALZPro**.

Levels of Cognitive Impairment

Cognitively unimpaired

Individuals may have biomarkers indicating evidence of Alzheimer's disease pathology but do not exhibit clinical signs of impairment or dementia.

Subjective cognitive decline

A patient (and/or care partner) may report experiencing more frequent or worsening confusion or memory loss even when objective cognitive testing does not indicate impairment.

Mild cognitive impairment

Patient exhibits and/or shows on objective cognitive testing early-stage memory loss or other cognitive ability loss (such as language or visual/spatial perception). These individuals can still maintain the ability to independently perform activities of daily living.

Mild, moderate or severe dementia

Mild or early-stage symptoms may include memory loss, difficulty with finding words, misplacing objects, carrying out tasks, or difficulty with planning or organizing. Patients with mild dementia require minimal assistance with higher level of daily chores.

Moderate or middle-stage symptoms include more pronounced cognitive impairments, mood, personality or behavioral changes, and difficulty with executive functioning and activities of daily living. Patients with moderate dementia require more care and assistance to perform daily tasks.

Severe or late-stage symptoms include inability to respond to their environment or communicate effectively. Memory and cognitive skills worsen, and personality changes may take place. Individuals with severe dementia require round-the-clock care.

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