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DeAR-GP®

Dementia Assessment Referral to GP

Date ____/____/______

Dear GP/Healthcare Professional,

Re: Patient name: ___________________________Date of birth: ____ / ____ / ________

Locality: _______________________________________Phone: ___________________

DeAR-GP (Dementia Assessment Referral to GP) is a simple case finding tool which has been developed by the Health Innovation Network (the Academic Health Science Network for South London) to assist primary and secondary care practitioners to identify residents with possible dementia in community health settings. The Case Management Team (including Care Navigators) are trained and encouraged to use DeAR-GP if they are concerned a patient may have dementia.

There is a concern about the above patient and a member of the Case Management Team have used the case finding tool, the results of which can be seen overleaf. Staff may collect further information and – if available – this information is documented overleaf on the observation chart.

We stress this is not a screening tool: staff are instructed only to use it with those patients who display signs or symptoms raising concern. Furthermore, identification by using this case finding tool does not confirm a diagnosis and is not a diagnostic exercise.

We thank you for reviewing the results and considering further action, as appropriate.

[Name]
[Job Title]
[Organisation]

Patient must give verbal consent to having their memory assessed in this way.*

Patient name: ____________________ DOB: __/___/_____ Today's date: __/___/_____

Locality: _____________________ Healthcare Professional:_____________________

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For more information, see the guidance. Once completed, store this form in the agreed place for the review by the GP.

1

Must be answered "YES" to continue to sections 2-4:
Does this patient show signs of confusion and memory problems?

YES / NO

2

Observations over the last 3 months	Often	Sometimes	Rarely	Never
Forgetting things				
Repeating themselves				
Disorientation to time and/or place				
Restless				
Wandering				
Difficulty performing familiar tasks				
Speech and language problems				
Changes in mood and behaviour				
Other (please specify)				

3

6 Cognitive Impairment Test	Answer	Score
What year is it?		/4
What month is it?		/3
About what time is it?		/3
Count backwards from 20-1		/4
Say the months of the year in reverse		/4
Repeats address phrase		/10
6CIT Score		/28

*If the patient does not appear to have **capacity to consent**, finish here and submit it to the GP or memory nurse without sections 3 and 4.

4 Patient Health Questionnaire- 9 symptom checklist

Over the past 2 weeks, how often have you been bothered by any of the following problem?	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 asleep, 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're 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
Column Totals				
Add totals together				