

COGNITIVE IMPAIRMENT IN THE ELDERLY FLOW SHEET

This optional Flow Sheet is based on the Guideline,
Cognitive Impairment in the Elderly – Recognition, Diagnosis and Management
Web site: www.BCGuidelines.ca

NAME OF PATIENT	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	EDUCATION
DIAGNOSIS	DATE OF DIAGNOSIS	OCCUPATION	

CARE OBJECTIVES	SELF MANAGEMENT (Discuss with patient & caregiver)																																
<p>RISK FACTORS AND CO-MORBID CONDITIONS</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Obesity</td> <td><input type="checkbox"/> Diabetes</td> <td rowspan="2">Baseline Investigations (✓ when done; normal or add values prn)</td> </tr> <tr> <td><input type="checkbox"/> Smoker</td> <td><input type="checkbox"/> HTN</td> </tr> <tr> <td><input type="checkbox"/> Alcohol</td> <td><input type="checkbox"/> CAD</td> <td><input type="checkbox"/> FBG _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Atrial fib</td> <td><input type="checkbox"/> TSH _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> ECG _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> COPD</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Renal disease</td> <td><input type="checkbox"/> eGFR _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> CBC _____</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> B₁₂ _____</td> <td>SMMSE Score: _____ Date: _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Ca _____</td> <td>MoCA Score: _____ Date: _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> STS _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Obesity	<input type="checkbox"/> Diabetes	Baseline Investigations (✓ when done; normal or add values prn)	<input type="checkbox"/> Smoker	<input type="checkbox"/> HTN	<input type="checkbox"/> Alcohol	<input type="checkbox"/> CAD	<input type="checkbox"/> FBG _____		<input type="checkbox"/> Atrial fib	<input type="checkbox"/> TSH _____		<input type="checkbox"/> Asthma	<input type="checkbox"/> ECG _____		<input type="checkbox"/> COPD	<input type="checkbox"/> Other _____		<input type="checkbox"/> Renal disease	<input type="checkbox"/> eGFR _____		<input type="checkbox"/> Depression	<input type="checkbox"/> CBC _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> B ₁₂ _____	SMMSE Score: _____ Date: _____		<input type="checkbox"/> Ca _____	MoCA Score: _____ Date: _____		<input type="checkbox"/> STS _____		<p><input type="checkbox"/> Define management goals (Risk factor reduction; Treat co-morbid conditions; case management)</p> <p><input type="checkbox"/> Functional status (Baseline & review at each visit)</p> <p>IADLs:</p> <ul style="list-style-type: none"> • Housework • Meal prep • Shopping • Transportation • Finances • Managing meds <p>ADLs:</p> <ul style="list-style-type: none"> • Bathing/Toileting • Dressing • Mobility <p><input type="checkbox"/> Supports (home care, family, case manager, living situation)</p> <p><input type="checkbox"/> Caregiver issues (behaviour/sleep/mood)</p> <p><input type="checkbox"/> Living will/DNR discussion</p>
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VISITS				
DATE	BP	HR	WEIGHT Lbs Kg	(Review care objectives, management goals, functional status, symptoms, medications/pharmacy)
				BASELINE
				REVIEW CLINICAL ACTION PLAN

ANNUALLY
<p>VACCINATIONS</p> <p>Annual Flu: DATE <input style="width: 80px;" type="text"/> DATE <input style="width: 80px;" type="text"/> Pneumovax: DATE <input style="width: 80px;" type="text"/></p>