This guide provides a variety of tools to aid in the differential diagnosis of delirium, dementia, and depression. It is intended to be used as part of a comprehensive assessment.

1. Conduct a general health assessment.
   *Suggested labs: UA, TSH, B12, folate, chem 7, CBC, liver panel*
2. Rule out delirium for all patients with cognitive symptoms.
3. Conduct assessment for suicidal thoughts in all patients meeting criteria for depression.
4. If unusual or atypical symptoms are present (e.g., focal neurological symptoms, acute mental status changes):
   a. Consider neuroimaging
   b. Refer for specialty care

**Delirium**

- Consider delirium in ALL cases of mental status change
- Work up potential causes of delirium in all patients with mental status changes
- *Most common medical causes:*
  - Metabolic disorders
  - Infections, medications, hypoxemia
  - Dehydration
- *Most common medication causes:*
  - Anticholinergics, sedative hypnotics, opioids

**Dementia**

- Occurs commonly in sick older adults and in hospital settings, and in those with pre-existing cognitive problems.
- Marked by problems with attention and concentration.
- Shows a waxing and waning course; patients can seem normal at times.

**Depression**

- Use These Assessment Tools:
  - The PHQ-2
  - The PHQ-9

The PHQ-2 is a sensitive screening tool for all patients. PHQ-9 can be used to track changes in symptoms.

A PHQ-2 total score of ≥ 3 merits completing the PHQ-9.

**All patients with mood symptoms should be assessed for suicidal thoughts**

PHQ-2

Over the past two weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>Several days</th>
<th>&gt; Half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little or no interest or pleasure in doing things?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**PHQ-2: A suicide risk evaluation is required within 24 hours if: A total score of 3 or greater.**

Document responses in Mental Health Assistant Software package. Enter item scores responses, total score and result.

PHQ-9

Use the same scoring and first two items as the PHQ-2, and the 7 other items in the PHQ-9:

1. Trouble falling asleep, staying asleep, or sleeping too much?
2. Feeling tired or having little energy?
3. Poor appetite or overeating?
4. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down?
5. Trouble concentrating on things such as reading the newspaper or watching television?
6. Moving or speaking so slowly that others could have noticed, or being so fidgety and restless that you have been moving around a lot more than usual?
7. Thinking that you would be better off dead or that you want to hurt yourself in some way?

**PHQ-9: A suicide risk evaluation is required within 24 hours if:**

1. Total score is less than 10 and response to question #9 is 1, 2 or 3.
2. Total score is greater than 10.

Document responses in Mental Health Assistant Software package. Enter item scores responses, total score and result.
The AD8 is used to assess a patient’s functional status based on the report of a spouse, close family member or caregiver. It focuses on changes in the last several years caused by cognitive problems.

**DEMENTIA**

**Assessment Tools**  
(Choose one or more as appropriate)

- **DSM IV Criteria for Alzheimer’s**  
- **The Mini-Cog**  
- **The AD8**  
- **The FAST**  
- **The SLUMS**

1. **DSM –IV Criteria for Alzheimer’s Dementia**
   - The development of multiple cognitive deficits manifested by:
     1. **Memory Impairment**
     2. One or more of the following cognitive disturbances:  
        - (a) apraxia (language disturbance)  
        - (b) apraxia (impaired ability to carry out motor activities)  
        - (c) agnosia (failure to recognize objects)  
        - (d) disturbances in executive functioning (i.e., planning, organizing, sequencing, abstracting)
   - The cognitive deficits in A1 and A2 each cause significant impairment in social or occupational functioning.
   - The course is characterized by gradual onset and continuing cognitive decline.
   - The cognitive deficits are not due to other neurological or systemic conditions, or to substances.
   - The deficits do not occur exclusively during the course of a delirium.

2. **The Mini-Cog** is used as a brief assessment tool for cognitive impairment. It can be quickly administered in the clinic, and can guide the need for further evaluation.
   - Instruct the patient to listen carefully to and remember 3 unrelated words, and then to repeat the words. Example: apple, table, penny.
   - Ask the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read “one ten”.
   - Ask the patient to repeat the 3 previously stated words.

**SCORING:**

- 1 point for each recalled word after the clock drawing test (no points for initial recall)
- Patients recalling none of the three words are classified as: not cognitively impaired (Score = 3)
- Patients recalling all three words are classified as: cognitively impaired (Score = 0)

3. **The AD8**
   - The AD8 is used to assess function in patients with cognitive impairment and as a guide for medication therapy for patients with dementia. See VA Pharmacy Benefits Management (PBM) http://www.phm.vha.gov. Click on “Clinical Guidance” and “Criteria for Use”.

4. **The FAST** (Functional Assessment Staging)
   - The FAST is used to assess patients in cognitive impairment and as a guide for medication therapy for patients with dementia. See VA Pharmacy Benefits Management (PBM) http://www.phm.vha.gov. Click on “Clinical Guidance” and “Criteria for Use”.

5. **The SLUMS**
   - The SLUMS is used to assess for cogitive changes and to track clinical changes in dementia over time. It can be administered in 5-10 minutes. Scoring is normalized to education level. It has better psychometric properties than the MMSE.

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**DEMENTIA Assessment, continued:**

4. **FAST**
   - The FAST is used to assess patients in cognitive impairment and as a guide for medication therapy for patients with dementia. See VA Pharmacy Benefits Management (PBM) http://www.phm.vha.gov. Click on “Clinical Guidance” and “Criteria for Use”.

*Information should be provided by a knowledgeable informant and/or caregiver, and supplemented by clinical observations.*

**SCORING:** A single score is given, based on the highest consecutive disability noted. Additional non-consecutive deficits should also be noted clinically.

1. **No functional deficit (Normal)**
   - Subjective word difficulties (Normal Aging)
2. **Mild Impairment**
   - Decreased function in demanding settings or decreased ability to handle complex tasks (i.e. finances or planning dinner.)
3. **Moderate Impairment**
   - Requires assistance in choosing proper clothing
4. **Severe Impairment**
   - Difficulty with dressing, bathing, toileting, Urinary and/or fecal incontinence.
5. **Profound Impairment**
   - Can speak only about half a dozen intelligible different words or fewer
6. **Unable to talk without assistance**
7. **Unable to sit without assistance**
8. **Loss of ability to smile**
9. **Loss of ability to hold up head independently**

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**SCLUMS**

- **Name?** _________________  
- **Age?**_________  
- **Is patient alert?_________**  
- **Level of education?____________

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**Test administration:**

1. **What day of the week is it? – I**
2. **What is the year? – I**
3. **What state are we in? – I**
4. **Please remember these five objects. I will ask you what they are later.**

**Apple Pen Tin House Car**

1. **You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.**
   - How much did you spend? – 93
   - How much did you have left? – 74
   - How much do you have left? – 74
   - 86

2. **Please name as many animals as you can in one minute.**
   - 9 animals
   - 10-14 animals
   - 15+ animals

3. **What were the five objects I asked you to remember?**
   - 1-point for each one correct

4. **I am going to give you a series of numbers and I would like you to give them to me backwards, for example, if I say 24, you say 21.**
   - 87
   - 649
   - 493

5. **This is a clock face (give pt a circle), please draw the hands of the clock to read ten minutes to eleven.**
   - 2hr markers OK

6. **Can you sit up without assistance?**
   - 7c

7. **Speech ability limited to the use of a single intelligible word**
   - 7d

8. **Unable to talk without assistance**
9. **Loss of ability to smile**
10. **Loss of ability to hold up head independently**

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**SCORING:**

- **Items endorsed as “Yes, a change” are summed to yield the total AD8 score (maximum 8).**
- **0-1 normal**  
- **2 or greater = impairment is likely to be present.**

1. **Problems with judgment (e.g. falls for scams, bad financial decisions, buys gifts inappropriate for recipients)  
2. Reduced interest in hobbies/activities  
3. Repeats questions, stories or statements  
4. Trouble learning how to use a tool, appliance or gadget (e.g. VCR, computer, microwave, remote control)  
5. Forgets correct month or year  
6. Difficulty handling complicated financial affairs (e.g. balancing checkbook, income taxes, paying bills)  
7. Difficulty remembering appointments  
8. Consistent problems with thinking and/or memory

**TOTAL AD8 SCORE:**