



New England Division of General Practice

Memory Assessment Program Management Tool

(To claim Items 721 or 723, all sections must be completed)

Date: _____

PATIENT DETAILS

Name: _____ GP: _____ D.O.B.: _____

Address: _____

Phone _____ Work: _____ Mobile: _____

Aboriginal/Torres Islander: Yes No

DVA: Yes No

MAIN CONTACT PERSON Name: _____ Relationship to Patient: _____

Address: _____

Phone: _____ Work: _____ Mobile: _____

Support Network: _____

Commencement of symptoms: gradual abrupt.

History and time of presenting problems: _____

Level of insight-Patient's report: poor moderate good

Level of insight-Informant's report: poor moderate good

Short term memory loss: poor moderate good

Long term memory loss: poor moderate good

Hallucinations: _____

Delusions: _____

Past Medical History:

- Parkinson's Disease
- Stroke
- TIA
- Hyperlipidaemia
- Alcoholism
- Head Injury
- Depression
- Hypertension
- Other _____

Current Medications including vitamins, herbal remedies and over the counter medications:

(Attach summary from medical director)

Home medicines Review Referral if applicable (item no. 900)



New England Division of General Practice

<u>Activities of Daily Living</u>	I	R	D	<u>Instrumental Activities of Daily Living</u>	I	R	D
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telephone Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing/ grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Aids	Y <input type="checkbox"/>	N <input type="checkbox"/>		Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continent	Y <input type="checkbox"/>	N <input type="checkbox"/>		Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Handling Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Key I = Independent R = Requires assistant D = Dependent

Support persons needs (eg respite care, home care): _____

<p>Investigation checklist</p> <p>Pathology</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> FBC/ESR</td> <td style="width: 33%;"><input type="checkbox"/> BSL</td> <td style="width: 33%;"><input type="checkbox"/> VDRL</td> </tr> <tr> <td><input type="checkbox"/> Vitamin B12/folate</td> <td><input type="checkbox"/> TSH</td> <td><input type="checkbox"/> Urine MC&S</td> </tr> <tr> <td><input type="checkbox"/> LFT/EUC's</td> <td><input type="checkbox"/> CT Scan</td> <td><input type="checkbox"/> ECG</td> </tr> </table>	<input type="checkbox"/> FBC/ESR	<input type="checkbox"/> BSL	<input type="checkbox"/> VDRL	<input type="checkbox"/> Vitamin B12/folate	<input type="checkbox"/> TSH	<input type="checkbox"/> Urine MC&S	<input type="checkbox"/> LFT/EUC's	<input type="checkbox"/> CT Scan	<input type="checkbox"/> ECG	<p>Health Checklist</p> <p>BP _____ BMI _____ kg/m²</p> <p>Weight _____ Height _____</p> <p>Smoker <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> past >3months</p> <p>Number per day _____</p> <p>Alcohol Consumption <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Standard drinks per day _____</p>
<input type="checkbox"/> FBC/ESR	<input type="checkbox"/> BSL	<input type="checkbox"/> VDRL								
<input type="checkbox"/> Vitamin B12/folate	<input type="checkbox"/> TSH	<input type="checkbox"/> Urine MC&S								
<input type="checkbox"/> LFT/EUC's	<input type="checkbox"/> CT Scan	<input type="checkbox"/> ECG								

3. Mini-Mental State Examination (MMSE) Result: _____/30

4. Clock test: (Score 1 point for each)

1. Draws closed circle _____ 3. Includes all 12 correct numbers _____

2. Places numbers in correct positions _____ 4. Places hands in correct positions _____

Care plan recommendations	Provider	Review date
1. Geriatrician	Dr Gerald De Gabriele	
2. Psychologist	Dr Caroline Croft	
3. MAPPS Coordinator	Cate Doyle	
4.		

Geriatrician referral with accompanying letter. (Care Plan report will be sent to all referees nominated above)

Authority to proceed with care plan

GP Signature _____ Patient/Carer Signature _____ Date _____

Please Fax or Send to: 1. Dr G. DeGabriele, Armidale and New England Hospital, Ph: 02 6776 9713 Fax: 02 6771 1170 and
 2. Cate Doyle & Betty Whitten, New England Division Of General Practice, PO Box 1321 Armidale, NSW 2350
 Ph: 02 6771 1146 Fax: 02 67711146