Appendix J

Date: _____

To: _____
Physician Name

_____
Clinic Name

_____
Address

_____
City/State/Zip

RE: _____ _____ _____
Name *DOB* *Phone*

Dear Dr. _____

Enclosed you will find the results of a community-based cognitive screen for your patient listed above. The results indicate that this person may be experiencing cognitive impairment and should discuss related concerns with a physician. An explanation of the wide range of possible causes for memory loss or confusion was provided, including information about both treatable and untreatable conditions. Our agency recommended select schedule an appointment to discuss these concerns with you.

ADRC of XXXXX has been approved by the Wisconsin Department of Health Services to provide community-based memory screening to promote early detection of cognitive changes as well as to encourage diagnosis of persons with Alzheimer's disease or related dementias. The screening process is voluntary and offered when an individual expresses concerns about memory loss or confusion to agency staff. Your patient requested the results of the screening be shared with you. Results of the Animal Naming, Mini-cog or AD8 screens are attached for your review.

Additional notes to physician:

If your patient is diagnosed with a form of dementia, the agency is available to provide information and connection with supportive programming for both the person with dementia and the family caregiver. Agency staff received training on the specific needs of people with dementia and their families and can offer ongoing support in the community.

If you have any questions, please do not hesitate to contact me at Phone Number_____.

Sincerely,

Staff Name

Agency Name

General Contact Information