**Directions for using this form**

* Check to make sure the form complies with your organization’s policies concerning HIPAA. You can modify the form as needed to best fit the needs, goals, and guidelines of your agency.
* Fold the page in half on the dotted line
  + The information below the dotted line is written in language appropriate for healthcare providers and is not intended for clients to read or fill out
* Give the client time to read the paragraph at the top of the page or read it aloud for them
* Answer any questions the client may have about sharing their assessment results
* Ask them to fill out and sign the form
  + NOTE: Consider having client / patient complete the top part of the form BEFORE conducting the cognitive assessment.

Your Letterhead Here

**\*\* Test Results \*\***

**Cognitive Assessment**

Client

I give my permission for (name of community agency) to send my results from today’s health assessment to my physician/healthcare provider. This information will include my name, date of birth, phone number, and my assessment results. I understand that sharing this information is intended to coordinate my care.

Client name (PRINT):

First Middle Initial Last

Date of birth: / / Phone number: ( )

Name of Physician/Healthcare provider:

Clinic phone number: ( )

Client signature: Today’s date: / /

**TEST RESULTS** Pass / Fail

Detection Tool Client’s Score Normal Range

□ MiniCog /5 > 4

□ MoCA /30 > 26

□ SLUMS /30 > 27 (> 25 with less than high school educ.)

□ MMSE /30 > 26

□ Other / > Name:

Notes:

□ **Patient would like a nurse or staff member to call him/her to provide guidance on setting up a memory loss work-up.**

□ A score at this level is concerning for a decline in cognitive status that goes beyond normal age-related changes. Many patients with abnormal test results go on to receive a diagnosis of Mild Cognitive Impairment, Alzheimer’s disease or related dementia after a work-up.

□ A copy of the client’s assessment is attached.