



Performing a Cognitive Assessment and Developing a Care Plan in Primary Care¹⁻⁴

PeerView
Primary Care

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Cognitive Assessment and Care Plan (CPT 99483) Template

CACP_10: Written care plan		Today's date: _____	Next follow-up date: _____
Cognitive problems	Actions		
<input type="checkbox"/> None <input type="checkbox"/> Mild cognitive impairment <input type="checkbox"/> Mild dementia <input type="checkbox"/> Moderate stage <input type="checkbox"/> Late stage Type of dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Vascular <input type="checkbox"/> Mixed <input type="checkbox"/> Lewy Body <input type="checkbox"/> Frontotemporal <input type="checkbox"/> Other <input type="checkbox"/> Unknown; need further evaluation	<input type="checkbox"/> Advance care planning (living wills, family meeting) <input type="checkbox"/> Additional diagnostic testing (check all that apply) <input type="checkbox"/> Biomarker testing: _____ <input type="checkbox"/> Neuroimaging: MRI <input type="checkbox"/> Neuroimaging: CT <input type="checkbox"/> Neuroimaging: Amyloid PET <input type="checkbox"/> Neuroimaging: Other <input type="checkbox"/> Referral to neurologist/psychiatrist/geriatrician: _____ <input type="checkbox"/> Aging in place planning vs assisted living <input type="checkbox"/> Driving safely <input type="checkbox"/> Exercise your body <input type="checkbox"/> Exercise your brain (remediation, hobbies, games, computer, volunteering)		
<input type="checkbox"/> Healthy diet (dietician if needed, Meals on Wheels) <input type="checkbox"/> Lab testing: CBC/CMP/TSH/B12/folate/RPR/HIV/Other _____ <input type="checkbox"/> Legal/financial planning (power of attorney, guardianship, advance directives) <input type="checkbox"/> Medication: donepezil/rivastigmine/galantamine/memantine/donepezil + memantine <input type="checkbox"/> Medication: aducanumab/lecanemab <input type="checkbox"/> Medications to avoid (sleep aids, diphenhydramine) <input type="checkbox"/> Social engagement (clubs, church, sports)			
Neurological, mental health, behavioral, functional problems			
<input type="checkbox"/> Aggression <input type="checkbox"/> Delusions <input type="checkbox"/> Depression/suicide <input type="checkbox"/> Hallucinations <input type="checkbox"/> Decision making (capacity) <input type="checkbox"/> Safety <input type="checkbox"/> Sleep	<input type="checkbox"/> Alcohol avoidance <input type="checkbox"/> Autonomy promotion <input type="checkbox"/> Counseling <input type="checkbox"/> Driving safety <input type="checkbox"/> Environmental "rounds" <input type="checkbox"/> Exercise <input type="checkbox"/> Home safety <input type="checkbox"/> Medications: antidepressants/antipsychotics/anxiolytics/other: _____ <input type="checkbox"/> Music therapy <input type="checkbox"/> Reminiscence therapy <input type="checkbox"/> Relaxation therapy (art, pets, yoga, muscle relaxation) <input type="checkbox"/> Sleep patterns <input type="checkbox"/> Structure <input type="checkbox"/> Support group <input type="checkbox"/> Other		
Medical problems			
<input type="checkbox"/> Lung disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Vision and/or hearing <input type="checkbox"/> Swallowing <input type="checkbox"/> Cancer <input type="checkbox"/> Dental <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Urologic <input type="checkbox"/> Other	<input type="checkbox"/> Cardiac rehabilitation <input type="checkbox"/> Dental care <input type="checkbox"/> Fall prevention <input type="checkbox"/> Hearing/vision evaluation <input type="checkbox"/> Hospice care <input type="checkbox"/> Immunizations (flu, pneumococcal, tetanus booster, shingles) <input type="checkbox"/> Incontinence <input type="checkbox"/> Physical/occupational therapy evaluation <input type="checkbox"/> Pulmonary rehabilitation <input type="checkbox"/> Speech therapy evaluation <input type="checkbox"/> Other: _____		
Caregiver assistance			
<input type="checkbox"/> Adult day care <input type="checkbox"/> Aging in place (home modification) <input type="checkbox"/> Alzheimer's Association <input type="checkbox"/> Assistance from other resources (clubs, church, family, coworkers) <input type="checkbox"/> Barriers to assistance <input type="checkbox"/> Behavior management skills <input type="checkbox"/> Communication skills <input type="checkbox"/> Disease-specific resources <input type="checkbox"/> Environmental management <input type="checkbox"/> Home aides <input type="checkbox"/> Hospice			
<input type="checkbox"/> Legal/financial planning <input type="checkbox"/> Memory/communication aids (clock, calendar, glasses, hearing aids, pictures) <input type="checkbox"/> Medical/practical supplies <input type="checkbox"/> Medication management <input type="checkbox"/> Safety planning (guns, stairs, home hazards, falls) <input type="checkbox"/> Self-care actions <input type="checkbox"/> Senior alert system <input type="checkbox"/> Support group			

1. https://www.alz.org/media/Documents/Cognitive-Impairment-Care-Planning-Toolkit_012623.pdf. 2. Borson S et al. *Alzheimers Dement*. 2017;13:1168-1173. 3. Form adapted from <https://www.aafp.org/fpm/2019/0100/p11.html>. 4. <https://Championsforhealth.Org/Wp-content/Uploads/2021/09/Alzheimers-project-booklet-v11-082221-web.pdf>.