UNIVERSITY OF CALIFORNIA, IRVINE

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

Alzheimer's Disease Diagnostic
and Research Center

1100 Medical Plaza
Irvine, CA 92697-4285
Phone: (949) 824-ADTC (2382)
Fax: (949) 824-3049 FAX
http://www.mind.uci.edu

Date sent: _____

Thank you for calling the UCI Institute for Memory Impairments and Neurological Disorders. Enclosed you will find two questionnaires which need **to be completed by the caregiver/informant** and returned in the postage-paid envelope immediately. If we do not receive the forms by _____, your appointment times may be forfeited and have to be rescheduled.

Sincerely,

Switaya (Ken) Krisnasmit
Patient Care Coordinator
UCI Institute for Memory Impairments
and Neurological Disorders

Peter Knaup
Patient Care Coordinator
UCI Institute for Memory Impairments
and Neurological Disorders

Completed By

Informant Information (Please Print * required):

***Last name:** _____

***First name:** _____

***Phone number:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Address: _____

_____

City: _____

State: ____ **Zipcode:** _____ - _____

Note: Please fill in questions 1 thru 3 below about yourself.

1) Relationship:

1. £ Spouse or Spouse Equivalent
2. £ Son
3. £ Son-in-Law
4. £ Daughter
5. £ Daughter-in-Law
6. £ Other Relative _____
7. £ Friend
8. £ Neighbor
9. £ Paid Caregiver
99. £ Other: _____

2) Frequency Seen:

1. £ Once or more per day
2. £ Several times a week but less than once a day
3. £ About once per week
4. £ Less than once a week but two or three times a month
5. £ Once a month
6. £ Less than once a month

3) Known for:

1. £ Less than 6 months
2. £ Less than 1 year
3. £ Less than 2 Years
4. £ Less than 5 years
5. £ Less than 10 years
6. £ Greater than 10 years

Please complete the attached questionnaire with the requested information about the SUBJECT or PATIENT named:

Last: _____ **First:** _____

Please Enter Date Completed: _____ /_____ /_____

Completed By

Behavioral Changes (DSRS)

In each section, check the box that most closely applies to the patient. Please check only one selection per section.

1. Memory – Please check only one of the following:

1. o - Normal, no memory loss
2. o - Occasional "benign" forgetfulness of no consequence
3. o - Mild consistent forgetfulness with partial recollection of events
4. o - Moderate memory loss; more marked for recent events and severe enough to interfere with everyday activities
5. o - Severe memory loss, only well-learned material retained with newly learned material rapidly lost
6. o - Only fragments remain. Usually unable to remember basic facts such as the day of week, month and/or year, when last meal was eaten, or the name of the next meal
7. o – Unable to test due to speech and language difficulty and/or inability to follow instructions
8. o - Makes no attempt to communicate and is no longer aware of surroundings. Recognizes significant persons in their lives (close family, caregiver, etc.), but expresses this nonverbally (e.g., through facial expressions, changes in agitated behaviors, receptiveness to feeding)

2. Orientation – Please check only one of the following:

1. o - Normal, fully oriented to time and place
2. o - Some difficulty with time relationships, but not severe enough to interfere with everyday activities
3. o - Frequently disoriented in time and sometimes disoriented to new places
4. o - Almost always disoriented in time and usually disoriented to place
5. o - Unable to answer questions related to time of day or name of present location. Oriented to person only, can find own room or bathroom
6. o - Is unaware of questioner and makes no attempt to respond

3. Judgment – Please check only one of the following:

1. o - Normal, solves everyday problems and handles business and financial affairs well; judgment good in relation to past performance
2. o - Slight or only doubtful impairment in problem solving
3. o - Moderate difficulty in handling complex problems, but social judgments usually maintained
4. o - Severe impairment in handling problems, social judgment usually impaired
5. o - Unable to exercise judgment in either problem-solving or social situations

Behavioral Changes (DSRS)

4. Social Interactions / Community Affairs – Please check only one of the following:

1. o - Independent function at usual level in job, shopping, volunteer and social groups
2. o - Only mild impairment, of no practical consequence, but clearly different from previous years; still able to work (if applicable) but performance not up to previous standards (e.g., takes a lower level job)
3. o - Unable to function independently in community activities, although still able to participate to some extent and, to casual inspection, may appear normal; unable to hold a job or, if still working, requires constant supervision
4. o - No pretense of independent function outside of home; unable to hold a job but still participates in home activities with friends; casual acquaintances are aware of a problem. Appears well enough to be taken to functions (e.g., meals) outside of home
5. o - No longer participates in any meaningful way in home-based social activities involving people other than the primary caregiver. Appears to be too ill / impaired to be taken to functions outside of home

5. Home Activities / Responsibilities – Please check only one of the following:

1. o - Normal; life at home, hobbies, intellectual interests are well maintained
2. o - Some impairment in activities such as money management and house maintenance, but no effect on ability to shop, cook, or clean; still watches TV and reads newspaper with interest and understanding. Hobbies and intellectual interests are slightly impaired
3. o - Unable to perform activities related to money management (paying bills, etc.) or complex household tasks (maintenance); some difficulty with shopping, cooking and/or cleaning; losing interest in the newspaper and TV; more complicated hobbies and interests abandoned
4. o - No longer able to shop, cook, or clean without considerable help and supervision; no longer able to read the newspaper or watch TV with understanding
5. o - No significant function in home. No longer engages in any home-based activities

6. Personal Care – Please check only one of the following:

1. o - Normal; fully capable of self-care
2. o - Needs occasional prompting, but washes and dresses independently (i.e., he/she does most of it, but I help)
3. o - Requires assistance with dressing, hygiene, and personal upkeep (i.e., I do most of it, but he/she helps)
4. o - Totally dependent on others for help; does not initiate personal care activities

Behavioral Changes (DSRS) cont.

7. Speech / Language – Please check only one of the following:

1. o - Normal
2. o - Occasional difficulty with word finding, but able to carry on conversations
3. o - Unable to think of some words, may occasionally make inappropriate word substitutions
4. o - No longer spontaneously initiates conversations but can usually answer questions using sentences
5. o - Answers questions, but responses are often unintelligible or inappropriate; able to follow simple instructions
6. o - Speech usually unintelligible or irrelevant; unable to answer questions or follow verbal instructions
7. o - No response when spoken to; vegetative

8. Recognition – Please check only one of the following:

1. o - Normal
2. o - Occasionally fails to recognize more distant acquaintances or casual friends
3. o - Always recognizes family and close friends but usually not more distant acquaintances
4. o - Alert, occasionally fails to recognize family and/or close friends
5. o - Only occasionally recognizes spouse or caregiver
6. o - No recognition or awareness of the presence of others

9. Feeding – Please check only one of the following:

1. o - Normal
2. o - May require help cutting food and/or have limitations to the type of food, but otherwise, able to eat independently
3. o - Generally able to eat independently but may require some assistance
4. o - Needs to be fed; may have difficulty swallowing or requires feeding tube

10. Incontinence – Please check only one of the following:

1. o - Normal
2. o - Rare incontinence; bladder incontinence (generally less than one accident per month)
3. o - Occasional bladder incontinence (an average of two or more times a month)
4. o - Frequent bladder incontinence despite assistance (more than once per week)
5. o - Total incontinence

11. Mobility / Walking – Please check only one of the following:

1. o - Normal
2. o - May occasionally have some difficulty driving or taking public transportation, but fully independent for walking without supervision
3. o - Able to walk outside without supervision for short distances, but unable to drive or take public transportation
4. o - Able to walk within the home without supervision, but cannot go outside unaccompanied (3)
5. o - Requires supervision within the home, but able to walk without assistance (may use cane or walker)
6. o - Generally confined to a bed or chair; may be able to walk a few steps with help
7. o - Essentially bedridden, unable to sit or stand

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http://www.mind.uci.edu/

Thank you for your interest and commitment to our program. You are one of approximately 250 individuals who receive thorough neurological, physical, behavioral, and neuropsychological assessments at our clinic each year at no cost. Our goal is to better understand the aging process and improve the quality of life for older adults with memory or thinking problems. Your contribution will help us achieve these goals and is greatly appreciated.

Two appointments have been scheduled as follows:

NAME:_____

NEUROPSYCHOLOGICAL ASSESSMENT DATE: _____ TIME:_____ AM PM
(Please allow a minimum of 2 ½ hours for this visit)

NEUROLOGICAL ASSESSMENT DATE:_____TIME:_____ AM PM
(Please allow a minimum of 1 ½ hours for this visit)

PLACE**: Gottschalk Medical Plaza Building, Room 1100, University of California, Irvine, CA 92697-4285**

Additional tests, such as brain imaging (*e.g.,* MRI, SPECT scans) and blood analysis may be recommended by the doctors in addition to the neurological and neuropsychological examinations and our staff can help you with scheduling these appointments.

We request that a family member or someone knowledgeable about the patient be present for the entire visit to answer questions about the patient's medical history and his/her social, behavioral, and functional abilities.

Cancellation/Rescheduling Policy

We will call you one week prior to your assessment to confirm your appointment(s). Please make every effort to keep your appointment(s) as short notice cancellations and reschedule requests create a hardship for the clinic. If you must cancel/reschedule, please call as early as possible at (949) 824-2382. We prefer a 10-day advance notice of cancellation.

We look forward to seeing you soon.

Sincerely,

Switaya (Ken) Krisnasmit
Patient Care Coordinator
UCI Institute for Memory Impairments and Neurological Disorders

Enclosures: Patient/Caregiver Information Packet
2MCL-ADRC 6/20/08

Checklist

Please use this checklist to help you and your family member prepare for your upcoming appointment

Patient

- o Please be on time for appointments (if you arrive more than 15 minutes late, we may have to reschedule)
- o Wear easy to remove clothing/shoes; no panty hose if possible

Bring the following:

- o Glasses or hearing aids, if you use them
- o Insurance cards (Medicare, Medi-Cal, supplemental and/or private insurance)
- o Your Social Security number, date of birth, age, current address and phone number
- o **All** current medications, including vitamins and nutritional supplements
- o Durable power of attorney or an advanced healthcare directive, if you have them
- o A knowledgeable family member or other informant with you
- o A sweater or jacket as temperatures in the waiting and examination rooms vary

Caregiver/Informant

- o Fill out the enclosed paperwork and bring it with you to the office visit
- o If this is the patient's first visit and his/her medical records have not been mailed to the clinic, please bring them with you. This include the following:
  - Laboratory tests/bloodwork
  - Films (e.g., MRI, CT, PET scans)
  - Doctor's or medical reports
- o Bring a sweater or jacket as temperatures in the waiting and examination rooms vary
- o Please assist the patient by making sure they have all of the items listed on the left hand side of this form

Thank you again for your participation in this research project at the UCI Institute for Memory Impairments and Neurological Disorders. We look forward to seeing you soon. If you have any questions, please call **(949) 824-2382** during office hours (Monday-Friday 8:30 a.m. to 5:00 p.m.).

Institute for Memory Impairments and Neurological Disorders
University of California, Irvine
Longitudinal Study Program
Multi-Step Assessment Process

Participants in our research program receive the following multi-step evaluation:

- ***Clinical Evaluation:*** **The clinical evaluation typically involves two separate visits, each lasting between 1½ to 3 hours. A spouse, close friend, or relative who can provide information about the patient's past medical history and current abilities must be present at the time of the evaluation. The comprehensive clinical evaluation includes: (1) neurological and physical examinations; (2) neuropsychological testing to assess memory and other cognitive abilities (e.g. attention, language, visual-spatial, and reasoning skills); and (3) family interview to gather information related to the patient's social, behavioral, and functional abilities. There is no charge for this portion of the examination. Additional diagnostic tests such as brain imaging (*e.g.,* MRI, CT, or SPECT scan) and blood tests may be recommended and our staff can help schedule these appointments.**

- ***Family Conference:*** **One to two months after the clinical evaluation, the patient and his/her family are invited to participate in a "family conference." During this 2-hour conference, members of the team review the results of the evaluation and discuss the diagnosis and treatment plan in detail. When appropriate, referrals to other specialists and/or community agencies for additional services are provided.**

- **Comprehensive Report: Following the family conference, a comprehensive letter describing the findings from the clinical evaluation and treatment recommendations is mailed to the patient, his or her primary care physician and other designated parties.**

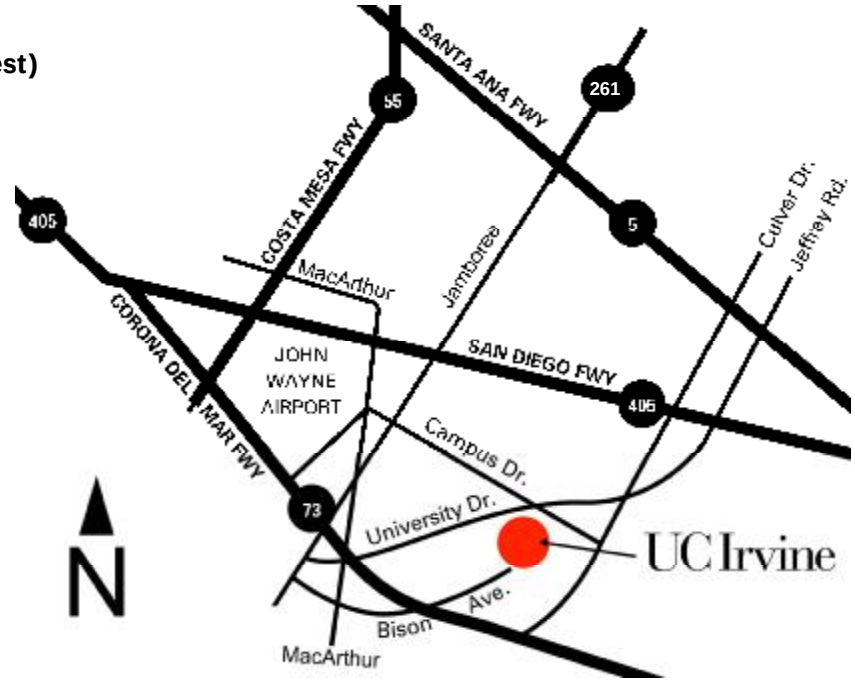
- ***Follow-Up Call:*** **Three to six months after the family conference, one of our staff will contact the informant or family member to inquire about the implementation of treatment recommendations and obtain feedback on which recommendations have been most helpful.**

For more information call (949) 824-2382 or write to:

Institute for Memory Impairments and Neurological Disorders
University of California, Irvine
1100 Gottschalk Medical Plaza
Irvine, CA 92697-4285

5 or 405 Freeway
From the north:
Exit at Jamboree Road and turn Right (West)
Turn Right on Jamboree Road
Turn Left on Campus Drive
Turn Right on University Drive
Turn Left on California
Turn Left on Academy
Turn Right on Medical Plaza Dr.
Park in "Patient Parking"

5 or 405 Freeway
From the south:
Exit Jeffery/University, go Left (West)
Follow University for several miles
Turn Left on California
Turn Left on Academy
Turn Right on Medical Plaza Dr.
Park in "Patient Parking"



73 Freeway / Toll way
From the north:
Exit at University Drive
Left on University Drive
Right on California Avenue
Left on Academy
Right on Medical Plaza Dr.
Park in "Patient Parking"

73 Freeway / Toll way
From the south:
Exit at Bison Avenue
Right on Bison Avenue
Left on California
Right on Academy
Right on Medical Plaza Dr.
Park in "Patient Parking"

Institute for Memory Impairments and Neurological Disorders
1100 Gottschalk Medical Plaza
Irvine, CA 92697-4285
(949) 824-2382

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INSTITUTE *for* MEMORY IMPAIRMENTS
and NEUROLOGICAL DISORDERS

1100 Medical Plaza Drive
Irvine, CA 92697-4285
Phone: (949) 824-2382
Fax: (949) 824-3049
http://www.mind.uci.edu

Dear Patient and Family Members,

An area of concern often expressed by family members is the safe driving competence of a patient diagnosed with a dementia such as Alzheimer's disease.

California physicians are required to report patients diagnosed with a dementia to the local health department. In addition, physicians must report other neurological conditions that would likely interfere with safe driving including, but not limited to, seizures. The local health departments send the reports to the California Department of Health Services, which forwards them to the Department of Motor Vehicles (DMV). The reports are used by the DMV to evaluate the driving competence of the persons reported. The purpose of reporting and evaluating the driving competence of persons is to prevent motor vehicle accidents by restricting unsafe drivers from California roadways.

The patient's driving competence may be diminished with progressive deficits in memory, impaired orientation to time or space, and impaired judgment. Impaired executive functioning, reflected for example by low scores on part B of the Trail Making Test, may be associated with an increased risk for car accidents.

The DMV may assess the patient's driving competence by a road test. When action is taken in cases of Alzheimer's disease and related disorders, it is most often restriction, suspension or revocation of the driving privilege. Possible restrictions include limiting driving to certain places or times. After evaluating the reported person's driving competence, the DMV will take action most appropriate to the specific case.

The Alzheimer's Assessment Center is required to report any patient diagnosed with a dementia as well as other conditions, as indicated above. We will be following this law. If you have any questions about this procedure, please contact us at (949) 824-2382.

Sincerely,

M.D.

Gaby T. Thai, M.D.
Associate Clinical Professor Department of Neurology
UCI Alzheimer's Disease Research and Treatment Center
Institute for Memory Impairments and Neurological Disorders

Patient Label

UNIVERSITY of CALIFORNIA · IRVINE
HEALTHCARE

AUTHORIZATION TO OBTAIN INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

Patient Name:_____ **Medical Record Number:**_____

Date of Birth:_____

I the undersigned hereby authorize:

_____

Name of physician or facility to release health information

_____

Physician or Facility Street address

_____

City, State **Zip Code**

_____

Telephone **Fax Number**

To be released to:

☐ UCI Family Health Center - Anaheim 300 W. Carl Karcher Way, Anaheim, CA 92801
☒ **UCI Institute for Memory Impairments and Neurological Disorders**
1100 Medical Plaza Dr., Irvine, CA 92697
☐ UCI Manchester Pavilion - Orange 200 South Manchester Ave., Orange, CA 92868
☐ UCI Medical Pavilions - Orange 101 The City Drive South, Orange, CA 92868
☐ UCI Family Health Center - Santa Ana 800 N. Main Street, Santa Ana, CA 92701

UCI Institute for Memory Impairments and Neurological Disorders, P: (949) 824-2382 F: (949) 824-3049
UC Irvine Healthcare Unit and/or Clinic requesting Health Information

Information to be RELEASED

☒ Discharge Summary	☒ Laboratory Reports	☒ Emergency Medicine Reports
☐ Billing Statements	☐ Dental Records	☒ History & Physical Exams
☒ Pathology Reports	☒ Operative Reports	☒ Diagnostic Imaging Reports
☒ EKG ☒ Progress Notes ☐ Vaccinations/Immunizations	☒ Radiology Reports ☒ Outpatient Clinic Records	☒ Consultations
☐ Other_____		

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

_____

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. 12343456 §§2.34 and 2.35).

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)

☐ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code § 120980(g)).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code § 124980(g)).

Patient Label

UNIVERSITY of CALIFORNIA · IRVINE
HEALTHCARE

AUTHORIZATION TO OBTAIN INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

THE PURPOSE OF THIS RELEASE IS (check one or more)

- ☒ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/patient representative
- ☐ Other (state reason)

NOTICE

UC Irvine Healthcare and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan of which, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Care provider listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I am entitled to receive a copy of this Authorization.
- Photocopy/Faxed copy may be used as an original.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after date of signing this form.

SIGNATURE

_____ Date:_____
(Signature of Patient or Patient's Legal Representative)

_____ Time:_____ AM/PM
Printed Name

_____
(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

_____
Witness or Translator

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

Completed By

Informant Information (Please Print * required):

***Last name:** _____

***First name:** _____

***Phone number:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Address: _____

_____

City: _____

State: ____ **Zipcode:** _____ - _____

Note: Please fill in questions 1 thru 3 below about yourself.

1) Relationship:

1. £ Spouse or Spouse Equivalent
2. £ Son
3. £ Son-in-Law
4. £ Daughter
5. £ Daughter-in-Law
6. £ Other Relative _____
7. £ Friend
8. £ Neighbor
9. £ Paid Caregiver
99. £ Other: _____

2) Frequency Seen:

1. £ Once or more per day
2. £ Several times a week but less than once a day
3. £ About once per week
4. £ Less than once a week but two or three times a month
5. £ Once a month
6. £ Less than once a month

3) Known for:

1. £ Less than 6 months
2. £ Less than 1 year
3. £ Less than 2 Years
4. £ Less than 5 years
5. £ Less than 10 years
6. £ Greater than 10 years

Please complete the attached questionnaire with the requested information about the SUBJECT or PATIENT named:

Last: _____ **First:** _____

Please Enter Date Completed: _____ /_____ /_____

Completed By

Subject Demographic Information

Date of Birth:

1. Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___ (i.e., Month / Day / Year)

2. Place of Birth (Please list City, State or City, Country):

_____

3. 1. £ Yes 0. £ No Is the patient from a multiple birth (i.e., twin, triplet, etc.)?
   A. If 3 is Yes please indicate Twin Type:
   1. £ Fraternal 2. £ Identical 9. £ Unknown

Sex:

4. £ Male £ Female

Ethnicity:

5. 1. £ Yes 0. £ No Are you Spanish / Hispanic / Latino (if yes, please select region below)
   A. 1. £ North American (e.g., Mexican, Mexican-American, Chicano, etc.)
   2. £ South American 5. £ Cuban
   3. £ Central American 6. £ Haitian
   4. £ Puerto Rican 7. £ Dominican

   99. £ Other (specify) _____

Race:

6. 1. £ American Indian (North/South/Central American)/Alaskan Native (Aleut and Eskimo)
   2. £ Asian
   3. £ Asian Indian 8. £ Hmong
   4. £ Cambodian 9. £ Korean
   5. £ Chinese 10. £ Laotian
   6. £ Filipino 11. £ Vietnamese
   7. £ Japanese

   12. £ Black, African-American
   13. £ Caucasian / White
   14. £ Pacific Islander
   15. £ Native Hawaiian 16. £ Guamanian 17. £ Samoan

   99. £ Other Race (specify) _____

Handedness:

7. Which is the patient's dominant hand (i.e., hand used to write or throw with)?
   1. £ Right 2. £ Left 3. £ Both (Ambidextrous)

First Language Learned:

8. 1. £ English 4. £ Korean 99. £ Other (specify) _____
   2. £ Spanish 5. £ Cantonese
   3. £ Vietnamese 6. £ Mandarin

Primary Language Spoken:

9. 1. £ English 4. £ Korean 99. £ Other (specify) _____
   2. £ Spanish 5. £ Cantonese
   3. £ Vietnamese 6. £ Mandarin

Subject Demographic Information

Subject Demographic Information

Sexual Orientation / Identity:

10. Does the subject consider him/herself to be?

1. £ Heterosexual or straight
2. £ Gay or Lesbian
3. £ Bisexual
8. £ No Answer
9. £ Don't Know

Marital Status:

11.
1. £ Never Married
2. £ Married
3. £ Widowed
4. £ Divorced
5. £ Separated
6. £ Living as Married

99. £ Other (specify) _____

Living Situation:

12.
1. £ Living in household Alone
2. £ Living in household with Spouse / Spouse equivalent only
8. £ Living in household with Spouse / Spouse equivalent and others
3. £ Living in household with Relatives
4. £ Living in household with Non-Relatives Only
5. £ Living in Health Related Facility
6. £ Assisted Living Facility
7. £ Retirement Community

99. £ Other (specify) _____

Independence:

13. Check the box for the category which best describes the level of activity the subject is "Able to do."

1. £ Able to live independently
2. £ Requires some assistance with complex activities (Finances, Shopping)
3. £ Requires some assistance with basic activities (Eating, Dressing, Bathing)
4. £ Completely dependent

Driver's License:

14. 1. £ Yes 0. £ No **Does the subject have a valid driver's license?**

Driving Status:

15. What is the subject's current driving status?

1. £ Never drove
2. £ Does not drive
3. £ Currently Driving

a) ***If currently driving, how well does the subject drive?***

(1) £ Drives to previous standards (no problems)

(2) £ Drives but needs assistance

If needs assistance, please check all that apply

1. £ Drives but needs assistance with directions
2. £ Drives but has gotten lost multiple times recently
3. £ Drives but has had minor accidents in the last year

a. How many? _____

4. £ Drives but has had to call to get assistance
5. £ Family would not feel safe if they were a passenger in vehicle

Subject Demographic Information

Annual Income:

16.
1. £ Less than $15,000
2. £ $15,000 - $20,000
3. £ $21,000 - $40,000
4. £ $41,000 - $60,000
5. £ $61,000 - $80,000
6. £ $81,000 - above
7. £ Do not know
8. £ Choose not to Answer

Occupation:

17. A. Current / Prior Occupation (specify) _____

B. Current Working Status

1. £ Full-time (more than 35 hours per week)
2. £ Part-time (less than 35 hours per week)
3. £ Retired - Date: ___ ___ / ___ ___ ___ ___ (Month / Year)
4. £ Never worked

99. £ Other (specify) _____

Education:

18. Please indicate highest certificate or degree obtained

A.
1. £ No Formal Schooling
2. £ Grade School (6 years)
3. £ Jr. High School (8 years)
4. £ High School (12 years)
5. £ Associate / Two-Year College (14 years)
6. £ Bachelors (16 years)
7. £ Masters (18 years)
8. £ Doctorate (20 or more years)

B. Total Years of Education: ___ ___

Subject Family History Worksheet

Please complete the following worksheet pages to the best of your ability.

The purpose of this form is to gather information concerning the subject's family history. To assist you in completing the following questions, we have provided definitions for certain specific terms.

The following apply to Father / Mother / Siblings / Children:

- **Biological for siblings means having the same mother or the same father and for children means the subject is one of the biological parents.**
- **Age first noticed refers to the age at which the symptoms began, not the age at which a formal diagnosis was made.**
- **Senility or Dementia refers to an impairment in memory and one or more other cognitive abilities, such as reasoning, language, or perceptual skills, that is sufficient to interfere with the person's social or occupational functioning and represents a significant decline from his/her previous level of functioning. There can be many different causes (etiology) of dementia including stroke, head injury, and Alzheimer's disease.**
- **Memory problems category should be marked when the person showed significant memory impairment but did not meet criteria for a dementia. This can include 'Mild Cognitive Impairment' (MCI) where the person is very forgetful but can still function relatively well in daily life activities.**
- **The Alzheimer's Disease category should be marked when the cause of the person's dementia was identified as being due to this disease either through a formal medical diagnosis or by brain autopsy.**
- **Psychiatric Illness category includes disorders such as paranoia, schizophrenia, and bipolar disorder.**
- **Stroke/TIA category includes a stroke or 'brain attack' which involve the sudden death of brain cells due to lack of oxygen when blood to the brain is impaired by a blockage (clot) or rupture of an artery. A TIA (transient ischemic attack) is a mini-stroke due to a temporary lack of blood/oxygen to the brain with symptoms lasting minutes to hours.**
- **Depression has been clinically diagnosed by a physician.**
- **Parkinson's disease has been clinically diagnosed by a physician.**

Subject Family History Worksheet

Please enter the following information on for the subject's mother and father.

	Birth Year	Check if deceased	Deceased Year
1. Mother	__ __ __ __	☐	__ __ __ __
2. Father	__ __ __ __	☐	__ __ __ __

If applicable, indicate the age at which the following symptom(s) were first noticed for mother and father. If a symptom was <u>present</u> but the age first noticed is unknown then please place a question mark (?) in the box for that symptom.

	Age first noticed				Check all that apply		
	Senility or Dementia (example = 82)	Memory Problems (example = 62)	Alzheimer's Disease (example = 67)	Psychiatric Illness (example = 57)	Stroke	Depression	Parkinson's Disease
3. Mother	___	___	___	___	☐	☐	☐
4. Father	___	___	___	___	☐	☐	☐

5. **How many biological siblings (brothers and sisters) does the subject have?** __ __

6. **How many biological children does the subject have?** __ __

Please indicate in the chart below the <u>number</u> of siblings and/or children that were affected by the following conditions.

	Indicate the total number affected						
	Senility or Dementia	Memory Problems	Alzheimer's Disease	Psychiatric Illness	Stroke	Depression	Parkinson's Disease
7. Siblings	__ __	__ __	__ __	__ __	__ __	__ __	__ __
8. Children	__ __	__ __	__ __	__ __	__ __	__ __	__ __

Medication Treatment History

Aricept

1. o Yes o No Has the subject ever taken Aricept?

If Yes, then please answer the following:
A. o Yes o No Is the subject still taking Aricept?

If NO, please indication the reason(s) for stopping (check all that apply):

(1) o Did not help	(6) o Diarrhea	(11) o Nightmares
(2) o Abdominal Pain/Cramps	(7) o Dizziness	(12) o Nausea
(3) o Agitation/Restlessness	(8) o Fatigue	(13) o Weight Loss
(4) o Anorexia	(9) o Headache	(14) o Vomiting
(5) o Confusion	(10) o Insomnia	(99) o Other: _____

Please indicated the amount of time Aricept was used:
(1) o < 1 Month (2) o 1-2 Months (3) o 3-6 Months
(4) o 7-12 Months (5) o > 12 Months

Exelon Tablets

2. o Yes o No Has the subject ever taken Exelon tablets?

If Yes, then please answer the following:
A. o Yes o No Is the subject still taking Exelon?

If NO, please indication the reason(s) for stopping (check all that apply):

(1) o Did not help	(6) o Diarrhea	(11) o Nightmares
(2) o Abdominal Pain/Cramps	(7) o Dizziness	(12) o Nausea
(3) o Agitation/Restlessness	(8) o Fatigue	(13) o Weight Loss
(4) o Anorexia	(9) o Headache	(14) o Vomiting
(5) o Confusion	(10) o Insomnia	(99) o Other: _____

Please indicated the amount of time Exelon was used:
(1) o < 1 Month (2) o 1-2 Months (3) o 3-6 Months
(4) o 7-12 Months (5) o > 12 Months

Exelon Patches

3. o Yes o No Has the subject ever taken Exelon Transdermal Patches?

If Yes, then please answer the following:

A. o Yes o No Is the subject still using the Exelon Patch?

If NO, please indication the reason(s) for stopping (check all that apply):

(1) o Did not help	(6) o Diarrhea	(11) o Nightmares
(2) o Abdominal Pain/Cramps	(7) o Dizziness	(12) o Nausea
(3) o Agitation/Restlessness	(8) o Fatigue	(13) o Weight Loss
(4) o Anorexia	(9) o Headache	(14) o Vomiting
(5) o Confusion	(10) o Insomnia	(99) o Other: _____

Please indicated the amount of time Exelon patch was used:

(1) o < 1 Month (2) o 1-2 Months (3) o 3-6 Months
(4) o 7-12 Months (5) o > 12 Months

Razadyne / Reminyl

4. o Yes o No Has the subject ever taken Razadyne / Reminyl?

If Yes, then please answer the following:

A. o Yes o No Is the subject still taking Razadyne?

If NO, please indication the reason(s) for stopping (check all that apply):

(1) o Did not help	(6) o Diarrhea	(11) o Nightmares
(2) o Abdominal Pain/Cramps	(7) o Dizziness	(12) o Nausea
(3) o Agitation/Restlessness	(8) o Fatigue	(13) o Weight Loss
(4) o Anorexia	(9) o Headache	(14) o Vomiting
(5) o Confusion	(10) o Insomnia	(99) o Other: _____

Please indicated the amount of time Razadyne was used:

(1) o < 1 Month (2) o 1-2 Months (3) o 3-6 Months
(4) o 7-12 Months (5) o > 12 Months

Memantine / Namenda

5. o Yes o No Has the subject ever taken Namenda?

If Yes, then please answer the following:

A. o Yes o No Is the subject still taking Namenda?

If NO, please indication the reason(s) for stopping (check all that apply):

(1) o Did not help
(2) o Abdominal Pain/Cramps
(3) o Agitation/Restlessness
(4) o Anorexia
(5) o Confusion
(6) o Constipation
(7) o Diarrhea
(8) o Dizziness
(9) o Fatigue
(10) o Headache
(11) o Hypertension
(12) o Insomnia
(13) o Nightmares
(14) o Nausea
(15) o Weight Loss
(16) o Vomiting
(99) o Other: _____

Please indicated the amount of time Namenda was used:

(1) o < 1 Month (2) o 1-2 months (3) o 3-6 Months
(4) o 7-12 Months (5) o > 12 Months

Functional Activities Questionnaire (Informant)

Within the last 30 days, did the subject have any difficulty or need help with any of the following areas because of cognitive dysfunction? (*i.e., problems with memory or other thinking abilities*)

All questions require a Single selection to be made.	Normal (or) Never did, but could do now	Has difficulty, but does by self (or) Never did, but would have difficulty now	Requires Assistance	Dependant on others
1. Writing checks, paying bills, balancing a checkbook	o	o	o	o
2. Assembling taxes, managing business affairs, or papers	o	o	o	o
3. Shopping alone for clothes, groceries, household necessities	o	o	o	o
4. Playing a game or skill, working on a hobby	o	o	o	o
5. Heating water, making a cup of coffee (tea) and turning off stove	o	o	o	o
6. Preparing a balanced meal	o	o	o	o
7. Keeping track of current events	o	o	o	o
8. Paying attention and understanding a T.V. program, discussing a book / newspaper article	o	o	o	o
9. Remembering appointments, holidays, family occasions, or medications	o	o	o	o
10. Driving, traveling out of the neighborhood, arranging to take the bus or a taxi	o	o	o	o

Functional Activities Questionnaire (Informant)

Bristol Activities of Daily Living Scale (BADLS)

This questionnaire is designed to reveal the everyday ability of people who have memory difficulties of one form or another. For each activity, (No's. 1-20), statements a-e refer to a different level of ability. Thinking of the **LAST TWO WEEKS**, please check the box that represents your relative's/friend's ability. **Only 1 box** should be checked for each activity.(If in doubt about which box to check, choose the level of ability which best represents the individual's average performance over the **LAST TWO WEEKS**)

1. MEAL PREPARATION

1. **o Selects and prepares food as required**
2. **o Able to prepare food if ingredients are set out for him/her**
3. **o Can prepare food if prompted step-by-step**
4. **o Unable to prepare food even with prompting and supervision**
5. **o Not applicable – never did**
6. **o Not applicable – performed by others / this service is provided**

2. EATING

1. **o Eats appropriately using correct utensils**
2. **o Eats appropriately if food is made manageable and/or uses a spoon**
3. **o Uses fingers to eat food**
4. **o Needs to be fed**

3. DRINK PREPARATION

1. **o Selects and prepares drinks (e.g., coffee, tea, lemonade) as required**
2. **o Can prepare drinks if ingredients left available**
3. **o Can prepare drinks if prompted step-by-step**
4. **o Unable to make a drink even with prompting and supervision**
5. **o Not applicable – performed by others / this service is provided**

4. DRINKING

1. **o Drinks appropriately**
2. **o Drinks appropriately with aids (e.g., beakers, straw)**
3. **o Does not drink appropriately even with aids but attempts to**
4. **o Has to have drinks administered (fed) by others**

5. DRESSING

1. **o Selects appropriate clothing and dresses without any help**
2. **o Puts clothes on in wrong order and/or back to front and/or dirty clothing**
3. **o Unable to dress self but moves limbs to assist**
4. **o Unable to assist and requires total dressing**

Bristol Activities of Daily Living Scale (BADLS) (cont.)

Only 1 box should be checked for each activity.(If in doubt about which box to check, choose the level of ability which best represents the individual's average performance over the LAST TWO WEEKS)

6. PERSONAL HYGIENE / GROOMING

1. o **Washes regularly and independently**
2. o **Can wash self if given soap, washcloth, and towel**
3. o **Can wash if prompted and supervised**
4. o **Unable to wash self and needs full assistance**

7. TEETH CLEANING

1. o **Cleans own teeth/dentures regularly and independently**
2. o **Cleans teeth/dentures if given appropriate items**
3. o **Requires some assistance, toothpaste on brush, brush to mouth, etc.**
4. o **Full assistance given**

8. BATHING / SHOWERING

1. o **Bathes regularly and independently**
2. o **Needs bath to be drawn or shower turned on but washes self independently**
3. o **Needs supervision and prompting to wash**
4. o **Totally dependent, needs full assistance**

9. TOILETING

1. o **Uses toilet appropriately when required**
2. o **Needs to be taken to the toilet and given assistance**
3. o **Incontinent of urine or feces**
4. o **Incontinent of urine and feces**

10. TRANSFERS

1. o **Can get in/out of a chair unaided**
2. o **Can get into a chair but needs help to get out**
3. o **Needs help getting in and out of chair**
4. o **Totally dependent on being put into and lifted from chair**

11. MOBILITY

1. o **Walks independently**
2. o **Walks with assistance (i.e. uses furniture or someone's arm for support)**
3. o **Uses physical aids (e.g., walker, cane, sticks) to walk**
4. o **Unable to walk**

Bristol Activities of Daily Living Scale (BADLS)(cont.)

Only 1 box should be checked for each activity.(If in doubt about which box to check, choose the level of ability which best represents the individual's average performance over the LAST TWO WEEKS)

12. ORIENTATION TO TIME

1. o Fully oriented to time/day/date etc.
2. o Unaware of time/day/date etc. but seems unconcerned
3. o Repeatedly asks the time/day/date
4. o Mixes up night and day

13. ORIENTATION TO PLACE

1. o Fully oriented to surroundings
2. o Oriented to familiar surroundings only
3. o Gets lost in home, needs reminding where bathroom is, etc.
4. o Does not recognize home as own and attempts to leave

14. COMMUNICATION

1. o Able to hold appropriate conversation
2. o Shows understanding and attempts to respond verbally with gestures
3. o Can make him-or herself understood but has difficulty understanding others
4. o Does not respond to or communicate with others

15. TELEPHONE

1. o Uses telephone appropriately, including obtaining correct number
2. o Uses telephone if number given verbally/visually or pre-dialed
3. o Answers telephone but does not make outgoing calls
4. o Unable/unwilling to use telephone at all

16. HOUSEWORK/GARDENING

1. o Able to do housework/gardening to previous standard
2. o Able to do housework/gardening but not to previous standard
3. o Limited participation in these activities even with a lot of supervision
4. o Unwilling/unable to participate in previous housework/gardening activities
5. o Not applicable – never did
6. o Not applicable – performed by others / this service is provided

17. SHOPPING

1. o Shops to previous standard
2. o Only able to shop for 1 or 2 items with or without a list
3. o Unable to shop alone, but participates when accompanied
4. o Unable to participate in shopping even when accompanied
5. o Not applicable – never did
6. o Not applicable – performed by others / this service is provided

Bristol Activities of Daily Living Scale (BADLS) (cont.)

Only 1 box should be checked for each activity.(If in doubt about which box to check, choose the level of ability which best represents the individual's average performance over the LAST TWO WEEKS)

18. MANAGING FINANCES

1. o **Responsible for own finances at previous level**
2. o **Unable to write check but can sign name and recognizes money values**
3. o **Can sign name but unable to recognize money values**
4. o **Unable to sign name or recognize money values**
5. o **Not applicable – never did**
6. o **Not applicable – performed by others / this service is provided**

19. GAMES/HOBBIES

1. o **Participates in pastimes/activities to previous standard**
2. o **Participates but needs instruction/supervision**
3. o **Reluctant to join in, very slow, needs coaxing**
4. o **No longer able or willing to join in, hobbies abandoned**

20. TRANSPORTATION / DRIVING

1. o **Able to drive, cycle, or use public transport (e.g., bus, train, taxi) independently**
2. o **Unable to drive, but uses private and public transport or bike independently**
3. o **Can travel with others by car but unable to use public transport on his/her own**
4. o **Unable/unwilling to use private or public transport even when accompanied**

Bristol Activities of Daily Living Scale (BADLS) (cont.)

Mobility Questionnaire

1. Degree of independence when walking (Please check only one):

1. o Normal (*i.e.,* able to walk independently without supervision or assistance)
2. o Walks slowly without using a supportive device (cane, walker, etc.) or physical support from others, is very cautious, is at risk for falling and/or has a history of falls
3. o Frequently uses a supporting device (cane, walker, etc.) when at home or in the community
4. o Requires physical support from others to walk
5. o Generally confined to a bed or wheelchair, only able to take a few steps without help

2. Level of endurance when walking (Please check only one):

1. o Normal (*i.e.,* walks at a relatively brisk pace without obvious signs of fatigue)
2. o Only able to walk for short distances (less than 1 city block)
3. o Shows signs of exertion when walking short distances (less than 1 city block) such as sweating, shortness of breath, a strong need to rest
4. o Unable to walk more then a few steps.

3. Does the patient/subject use any of the following devices?

1. o (1) Yes o (0) No - Cane
   If yes, then o (1) Chronic (Dependant) o (2) Acute (Temporary)
2. o (1) Yes o (0) No - Walker
   If yes, then o (1) Chronic (Dependant) o (2) Acute (Temporary)
3. o (1) Yes o (0) No - Wheelchair
   If yes, then o (1) Chronic (Dependant) o (2) Acute (Temporary)
4. o (1) Yes o (0) No - Shower rails/Bath Chairs
   If yes, then o (1) Chronic (Dependant) o (2) Acute (Temporary)

4. Does the patient/subject have difficulty climbing stairs unassisted?

o (1) Yes o (0) No

Mobility Questionnaire

Service Utilization

1. £ Yes £ No **Has the patient <u>ever</u> attended Adult Day Care?**

2. £ Yes £ No **Is he / she <u>currently</u> enrolled in Adult Day Care?**
   If Yes, please indicate the following:
   Number of days per week: _____
   Location: _____

3. £ Yes £ No **Was Adult Day Care previously <u>attempted</u> without enrollment?**
   If Yes, please explain reason(s) patient was not enrolled:
   _____
   _____
   _____

4. £ Yes £ No **Is the patient enrolled in the Safe Return program through the Alzheimer's Association?**
   If yes, is identification bracelet / necklace worn?
   £ Yes £ No

5. £ Yes £ No **Does the patient have a durable power of attorney for <u>Financial Affairs</u>?**

6. £ Yes £ No **Does the patient have a durable power of attorney for <u>Health Care</u>?**

7. £ Yes £ No **Does the patient have a conservator?**

8. £ Yes £ No **Does the patient have in-home health assistance (e.g., nurse, companion)?**

9. £ Yes £ No **Has the primary caregiver or spouse contacted the Alzheimer's Association?**

10. £ Yes £ No **Has the primary caregiver or spouse attended a support group?**

Service Utilization

Informant/Caregiver Rating of Patient's Depression

Has the patient exhibited any of the following symptoms during the <u>last</u> 2-week period, and do these symptoms represent a change from his / her previous functioning?

1. £ Yes £ No **Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observations made by others (e.g., appears tearful)**

2. £ Yes £ No **Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)**

3. Has the patient experienced any changes in weight or appetite?

a) £ Yes £ No **Significant weight loss when not dieting (e.g., a change of more than 5% of body weight in a month) How much weight lost? _____ lbs.**

b) £ Yes £ No **Decrease in appetite nearly every day**

c) £ Yes £ No **Significant weight gain (e.g., a change of more than 5% of body weight in a month) How much weight gained? _____ lbs.**

d) £ Yes £ No **An increase in appetite nearly every day**

4. How does the patient sleep?

a) £ **Insomnia (too little sleep) nearly every day**

b) £ **Hypersomnia (too much sleep) nearly every day**

c) £ **Normal sleeping pattern**

5. £ Yes £ No **Motor restlessness or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)**

6. £ Yes £ No **Fatigue or loss of energy nearly every day**

7. £ Yes £ No **Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)**

8. £ Yes £ No **Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)**

9. £ Yes £ No **Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide**

Informant/Caregiver Rating of Patient's Depression

Purpose

The purpose of this questionnaire is to determine if any of the following 12 behaviors have been present in your 'loved one'/subject during the last 30 days.

Instructions

Please read the screening question at the top of each section and mark your answer in the appropriate box (i.e., 'Yes,' 'No,' or 'Unable to determine').

If your answer to the screening question is positive, then check (√) the 'Yes' box and proceed to the set of sub-questions immediately below and mark any or all that apply.

If your answer to the screening question is negative, then check (√) the 'No' box and continue to the next screening question without answering the sub-questions.

If you are unable to answer the screening question, don't know, or are uncertain, then check (√) the 'Unable to determine' box and proceed to the next screening question.

Personality Changes

1. Delusions

Within the last 30 days, has the subject had beliefs that you know are not true? For example, insisting that people are trying to harm him/her or steal from him/her. Has he/she said that family members are not who they are or that their house is not their home? I'm not asking about mere suspiciousness: I'm interested if the subject is convinced that these things are happening to him/her.

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)
Does the subject have any of the following? (Check all that apply)

- **q He/she is in danger; others are planning to harm him/her?**
- **q Others are stealing from him/her?**
- **o Spouse is having an affair?**
- **o Unwelcome guests are living in the house?**
- **o Spouse or others are not who they claim to be?**
- **o His/her house is not his/her home?**
- **o Family members are planning to abandon him/her?**
- **o Television and/or magazine figures are actually present in the house?**
- **o Other unusual beliefs: _____**

When did these beliefs begin? ____ / _____ (Month / Year)

Rate the FREQUENCY or how often the *delusions* occur:
1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the subject):
1. **o Mild – the delusions are present but seem harmless and produce little distress in the patient; usually managed with redirection or reassurance**
2. **o Moderate – the delusions are distressing and disruptive to the subject; difficult to alleviate or control.**
3. **o Severe – the delusions are very disruptive and a major source of behavioral disturbance/suffering for the patient. Medications may be required to help manage/control them.**

Rate the DISTRESS you experience due to that symptom (how it affects you):
1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

2. Hallucinations

Within the last 30 days, has the subject had hallucinations such as false visions or voices? Does he/she seem to see, hear, or experience things that are not present? By this question we do not mean just mistaken beliefs such as stating that someone who has died is still alive; rather we are asking if the subject actually has abnormal experiences of sounds or visions.

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)
Does the subject experience any of the following? (Check all that apply)

- **q Describes hearing voices or acts like he/she hears voices**
- **q Talks to people who are not there**
- **o Describes seeing things not seen by others, or behaves as if he/she is seeing things not seen by others (e.g., people, animals, lights, etc.)**
  Describe: _____
- **o Reports smelling odors not smelled by others**
- **o Describes feeling things on his/her skin or otherwise appears to be feeling things crawling or touching him/her**
- **o Describes tastes that are without any known cause**
- **o Other unusual sensory experiences**
  Specify: _____

When did these hallucinations begin? ____ / _____ (Month / Year)

Rate the FREQUENCY or how often the *hallucinations* occur:
1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the subject):
1. **o Mild – the hallucinations are present but harmless and cause little distress for the patient; usually managed with redirection or reassurance.**
2. **o Moderate – the hallucinations are distressing and disruptive to the patient; difficult to alleviate or control.**
3. **o Severe – the hallucinations are very disruptive and a major source of behavioral disturbance for the patient. Medications may be required to help manage/control them.**

Rate the DISTRESS you experience due to that symptom (how it affects you):
1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

3. Agitation/Aggression

Within the last 30 days, has the subject had periods when he/she refuses to cooperate or won't let people help him/her? Is he/she hard to handle?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)

Does the subject do any of the following? (Check all that apply)

- **q Acts stubborn; insists on having things his/her way**
- **q Acts uncooperative; resists help from others**
- **o Get upset with those trying to care for him/her; resists activities (e.g., bathing or changing clothes)**
- **o Shouts or curses angrily**
- **o Slams doors, kicks furniture, or throws things**
- **o Attempts to hurt or hit others**
- **o Any other aggressive or agitated behaviors**
  Specify: _____

Rate the FREQUENCY or how often the *agitation/aggression* occur:

1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the subject):

1. **o Mild – the behavior is disruptive but can be managed with redirection or reassurance.**
2. **o Moderate – the behavior is disruptive and difficult to redirect or control.**
3. **o Severe – agitation is very disruptive and a major source of difficulty for the patient; there may be a threat of personal harm. Medications are often required to help manage the agitation/aggression.**

Rate the DISTRESS you experience due to that symptom (how it affects you):

1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

4. Depression/Dysphoria

Within the last 30 days, has the subject seemed sad or depressed? Does he/she say that he/she feels sad or depressed?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)

Does the subject do any of the following? (Check all that apply)

- **q Says or acts as if he/she is sad or low in spirits**
- **q Have periods of tearfulness or sobbing that seems to indicate sadness**
- **o Puts him/herself down or say that he/she feels like a failure**
- **o Says that he/she is a bad person and deserves to be punished**
- **o Seems very discouraged or says he/she has no future**
- **o Says that he/she is a burden to the family or that the family would be better off without him/her**
- **o Expresses a wish for death or talks about suicide**
- **o Shows other signs of depression or sadness**
  Specify:_____

Rate the FREQUENCY or how often the *depression/dysphoria* occurs:

1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the <u>subject</u>):

1. **o Mild – depression is distressing but usually responds to redirection or reassurance.**
2. **o Moderate – depression is distressing to the patient; depressive symptoms are spontaneously voiced by the patient and difficult to alleviate.**
3. **o Severe – depression is very distressing and a major source of suffering for the patient.**

Rate the DISTRESS you experience due to that symptom (how it affects <u>you</u>):

1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

5. Anxiety

Within the last 30 days, has the subject seemed very nervous, worried, or frightened for no apparent reason? Does he/she seem very tense or fidgety? Is the subject afraid to be apart from you?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)
Does the subject do any of the following? (Check all that apply)

- **q Becomes nervous and upset when separated from you (or his /her caregiver); does he/she cling to you to keep from being separated**
- **q Have periods (or complain of) shortness of breath, gasping, or sighing for no apparent reason other than nervousness**
- **q Have periods of feeling shaky, unable to relax, or feeling excessively tense**
- **o Says that he/she is worried about planned events**
- **o Complains of butterflies in his/her stomach or a racing or pounding of the heart in association with nervousness (not explained by ill health)**
- **o Avoids certain places or situations that make him/her nervous (riding in car, meeting friends, or being in crowds)**
- **o Shows any other signs of anxiety**
  Specify: _____

Rate the FREQUENCY or how often the *anxiety* occurs:
1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the subject):
1. **o Mild – anxiety is distressing but usually responds to redirection or reassurance.**
2. **o Moderate – anxiety is distressing to the patient; anxiety symptoms are spontaneously voiced by the patient and difficult to alleviate.**
3. **o Severe – anxiety is very distressing and a major source of difficulty/suffering for the patient.**

Rate the DISTRESS you experience due to that symptom (how it affects you):
1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

6. Elation/Euphoria

Within the last 30 days, has the subject seemed too cheerful or too happy for no reason? I don't mean the normal happiness that comes from seeing friends, receiving presents, or spending time with family members. I'm asking if the subject has a persistent and abnormally good mood or finds humor where others do not.

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)
Does the subject do any of the following? (Check all that apply)

q Appears to feel too good, or be too happy, different from his/her usual self
o Finds humor and laughs at things that others do not find funny
o Has a childish sense of humor with a tendency to giggle or laugh inappropriately
o Tells jokes or makes remarks that have little humor for others but seem funny to him/her
o Plays childish pranks such as pinching, or "keep away" for the fun of it?
o "Talks big" or claims to have more abilities or wealth than is true
o Shows other signs of feeling too good, or being too happy
Specify: _____

Rate the FREQUENCY or how often the *elation/euphoria* occurs:
1. o Occasionally - less than once per week
2. o Often - about once per week
3. o Frequently - several times per week but less than every day
4. o Very frequently – essentially continuously present

Rate the SEVERITY of the symptoms (how it affects the subject):
1. o Mild – elation is notable to friends and family but is not disruptive.
2. o Moderate – elation is notably abnormal and very evident.
3. o Severe – elation is very pronounced; patient is euphoric and finds nearly everything to be humorous.

Rate the DISTRESS you experience due to that symptom (how it affects you):
1. o Not distressing at all
2. o Minimal – slightly distressing, not a problem to cope with
3. o Mildly – not very distressing, generally easy to cope with
4. o Moderate – fairly distressing, not always easy to cope with
5. o Severe – very distressing, difficult to cope with
6. o Extreme or Very Severe – extremely distressing, unable to cope with

7. Apathy / Indifference

Within the last 30 days, has the subject lost interest in the world around him/her? Has he/she lost interest in doing things or lacks motivation for starting new activities? Is he/she more difficult to engage in conversation or in doing chores? Is the subject apathetic or indifferent?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)

Does the subject do any of the following? (Check all that apply)

- **q Less enthusiastic about his/her usual interests**
- **q Seems less interested in activities and plans of others**
- **o Less likely to initiate conversation**
- **o Less affectionate or lacking in emotions when compared to his/her usual self**
- **o Contributes less to household chores**
- **o Loss interest in friends and family members**
- **o Seems less spontaneous and less active than usual**
- **o Shows any other signs that he/she doesn't care about doing new things**
  Specify: _____

Rate the FREQUENCY or how often the *apathy/indifference* occurs:

1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the subject):

1. **o Mild – apathy is notable but produces little interference with daily routines; only mildly different from patient's usual behavior; patient responds to suggestions to engage in activities.**
2. **o Moderate – apathy is very evident; may be overcome by the caregiver with coaxing and encouragement; responds spontaneously only to powerful events such as visits from close relatives or family members.**
3. **o Severe – apathy is very evident and patient usually fails to respond to any encouragement/intervention by the caregiver or to external events.**

Rate the DISTRESS you experience due to that symptom (how it affects you):

1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

8. Disinhibition

Within the last 30 days, has the subject seemed to act impulsively without thinking? Does he/she do or say things that are not usually done or said in public? Does he/she do things that are embarrassing to you or others?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)
Does the subject do any of the following? (Check all that apply)

- **q Acts impulsively without appearing to consider the consequences**
- **q Talks to strangers as if he/she knew them**
- **q Says things to people that are insensitive or hurt their feelings**
- **o Says crude things or makes sexual remarks that they would not usually have said**
- **o Talks openly about very personal or private matters not usually discussed in public**
- **o Takes liberties to touch or hug others in a way that is out of character for him/her**
- **o Have problems with shoplifting or other misdemeanors**
- **o Shows other signs of loss of control of his/her impulses**
  Specify: _____

Rate the FREQUENCY or how often the *disinhibition* occurs:
1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the <u>subject</u>):
1. **o Mild – disinhibition is notable but usually responds to redirection and guidance.**
2. **o Moderate – disinhibition is very evident and difficult to overcome by the caregiver.**
3. **o Severe – disinhibition usually fails to respond to any intervention by the caregiver, and is a source of embarrassment or social distress.**

Rate the DISTRESS you experience due to that symptom (how it affects <u>you</u>):
1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

9. Irritability/Lability

Within the last 30 days, has the subject gotten irritated and easily disturbed? Are his/her moods very changeable? Is he/she abnormally impatient? We do not mean frustration over memory loss or inability to perform usual/everyday tasks; we are interested to know if the subject has <u>abnormal</u> irritability, impatience, or rapid emotional changes different from his/her usual self.

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)
Does the subject do any of the following? (Check all that apply)

q Cranky, and irritable
q Impatient, having trouble coping with delays or waiting for planned activities
o Has a bad temper, flying "off the handle" easily over little things
o Rapidly changes moods from one to another, being fine one minute and angry the next
o Has sudden flashes of anger
o Argumentative and difficult to get along with
o Shows any other signs of irritability
Specify: _____

Rate the FREQUENCY or how often the *irritability/lability* occurs:
1. o Occasionally - less than once per week
2. o Often - about once per week
3. o Frequently - several times per week but less than every day
4. o Very frequently – essentially continuously present

Rate the SEVERITY of the symptoms (how it affects the <u>subject</u>):
1. o Mild – irritability or lability is notable but usually responds to redirection and reassurance.
2. o Moderate – irritability or lability are very evident and difficult to overcome by the caregiver.
3. o Severe – irritability and lability are very evident; they usually fail to respond to any intervention by the caregiver, and they are a major source of distress.

Rate the DISTRESS you experience due to that symptom (how it affects <u>you</u>):
1. o Not distressing at all
2. o Minimal – slightly distressing, not a problem to cope with
3. o Mildly – not very distressing, generally easy to cope with
4. o Moderate – fairly distressing, not always easy to cope with
5. o Severe – very distressing, difficult to cope with
6. o Extreme or Very Severe – extremely distressing, unable to cope with

10. Aberrant Motor Behavior

Within the last 30 days, has the subject paced, does things over and over again such as opening closets or drawers, or repeatedly pick at things or wind string or threads?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)

Does the subject do any of the following? (Check all that apply)

- **q Pace around the house without apparent purpose**
- **q Engages in repetitive activities such as handling buttons, picking, wrapping string, etc.**
- **o Rummages around, opening and unpacking drawers and closets**
- **o Has repetitive activities or "habits" that he/she performs over and over again**
- **o Repeatedly puts on and takes off clothing**
- **o Fidgets excessively, seems unable to sit still, or bounces his/her feet or taps his/her fingers a lot**
- **o Does any other activity over and over**
  Specify: _____

Rate the FREQUENCY or how often the a*berrant motor behavior* occurs:

1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the subject):

1. **o Mild – abnormal motor activity is notable but produces little interference with daily routines.**
2. **o Moderate – abnormal motor activity is very evident; can be overcome by the caregiver.**
3. **o Severe – abnormal motor activity is very evident; it usually fails to respond to any intervention by the caregiver and is a major source of distress.**

Rate the DISTRESS you experience due to that symptom (how it affects you):

1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

11. Sleep / Night Time Behaviors

Within the last 30 days, has the subject had difficulty sleeping (do not count as present if the subject simply gets up once or twice per night to go to the bathroom and falls back asleep immediately)? Is he/she up at night? Does he/she wander at night, get dressed, or disturb your sleep?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)

Does the subject experience any of the following? (Check all that apply)

- **q Awakens you or the caregiver during the night**
- **q Wakes up too early in the morning (earlier then was his/her habit)**
- **q Sleeps excessively during the day**
- **o Has difficulty falling asleep**
- **o Gets up during the night (not counting use of bathroom if goes back to sleep)**
- **o Wanders, paces, or gets involved in inappropriate activities at night**
- **o Wakes up at night, dresses and plans to go out thinking it is daytime**
- **o Shows any other signs of night-time behavior that bothers you**
  Specify: _____

Rate the FREQUENCY or how often the s*leep behavior* occurs:

1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the <u>subject</u>):

1. **o Mild – night-time behaviors occur but they are not particularly disruptive.**
2. **o Moderate – night-time behaviors occur and disrupt the patient and the sleep of the caregiver; more than one type of night-time behavior may be present.**
3. **o Severe – night-time behaviors occur and are very disruptive; several types of night-time behaviors may be present; the patient is very distressed during the night and the caregiver's sleep is markedly disturbed.**

Rate the DISTRESS you experience due to that symptom (how it affects <u>you</u>):

1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

12. Appetite and eating changes

Within the last 30 days, has the subject had any changes in appetite, weight, or eating habits (do not count if the subject is incapacitated and has to be fed)? Has there been any change in the type of food he/she prefers?

o No (Skip to next behavior)
o Unable to determine (Skip to next behavior)

o Yes (Answer the questions below)
Does the subject had any of the following? (Check all that apply)

- **q A loss of weight**
- **q Gained weight**
- **q Changes in the kind of food he/she likes such as eating too many sweets, or other specific types of food**
- **o A loss of appetite**
- **o An increase in appetite**
- **o A change in eating behavior such as putting too much food in her/her mouth at once**
- **o Developed an eating behavior such as eating exactly the same types of food each day, or eating food in exactly the same order**
- **o Any other changes in appetite or eating**
  Specify: _____

Rate the FREQUENCY or how often the *appetite and eating changes* occur:
1. **o Occasionally - less than once per week**
2. **o Often - about once per week**
3. **o Frequently - several times per week but less than every day**
4. **o Very frequently – essentially continuously present**

Rate the SEVERITY of the symptoms (how it affects the subject):
1. **o Mild – changes in appetite or eating are present but have not led to changes in weight and are not disturbing.**
2. **o Moderate – changes in appetite or eating are present and cause minor fluctuations in weight.**
3. **o Severe – obvious changes in appetite or eating are present and cause fluctuations in weight, are embarrassing, or otherwise disturb the patient.**

Rate the DISTRESS you experience due to that symptom (how it affects you):
1. **o Not distressing at all**
2. **o Minimal – slightly distressing, not a problem to cope with**
3. **o Mildly – not very distressing, generally easy to cope with**
4. **o Moderate – fairly distressing, not always easy to cope with**
5. **o Severe – very distressing, difficult to cope with**
6. **o Extreme or Very Severe – extremely distressing, unable to cope with**

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form A1: Subject Demographics

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by intake interviewer per ADC scheduling records, subject interview, medical records, and proxy informant report (as needed). For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A1. Check only one box per question.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

Source of Referral:

1.	Subject enrolled in NACC MDS:	☐ 1 Yes	☒ 0 No	
2.	Primary reason for coming to ADC:	☐ 1 Participate in research study ☐ 2 Clinical evaluation	☐ 3 Other (*specify*): _____ ☐ 9 Unknown	
3.	Principal referral source:	☐ 1 Self/relative/friend ☐ 2 Clinician ☐ 3 ADC solicitation ☐ 4 Non-ADC study ☐ 5 Clinic sample	☐ 6 Population sample ☐ 7 Non-ADC media appeal (e.g., Alzheimer's Association) ☐ 8 Other (*specify*): _____ ☐ 9 Unknown	
4.	Presumed disease status at enrollment:	☐ 1 Case/patient/proband ☐ 2 Control/normal	☐ 3 No presumed disease status	
5.	Presumed participation:	☐ 1 Initial evaluation only	☐ 2 Longitudinal follow-up planned	

6.	ADC enrollment type:	☒ 1 Clinical Core ☐ 2 Satellite Core	☐ 3 Other ADC Core/project ☐ 4 Center-affiliated/non-ADC

7.	Subject's month/year of birth:	__ __/__ __ __ __

8.	Subject's sex:	☐ 1 Male	☐ 2 Female

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by intake interviewer per ADC scheduling records, subject interview, medical records, and proxy informant report (as needed). For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A1. Check only one box per question.

ADC Visit #:_ _ _

9. Does the subject report being of Hispanic/Latino ethnicity (i.e., having origins from a mainly Spanish-speaking Latin American country), regardless of race?	☐ 1 Yes ☐ 0 No	☐ 9 Unknown
9a. If yes, what are the subject's reported origins?	☐ 1 Mexican/Chicano/ Mexican-American ☐ 2 Puerto Rican ☐ 3 Cuban ☐ 4 Dominican	☐ 5 Central American ☐ 6 South American ☐ 50 Other (*specify*): _____ ☐ 99 Unknown
10. What does subject report as his/her race?	☐ 1 White ☐ 2 Black or African American ☐ 3 American Indian or Alaska Native	☐ 4 Native Hawaiian or Other Pacific Islander ☐ 5 Asian ☐ 50 Other (*specify*): _____ ☐ 99 Unknown
11. What additional race does subject report?	☐ 1 White ☐ 2 Black or African American ☐ 3 American Indian or Alaska Native ☐ 4 Native Hawaiian or Other Pacific Islander	☐ 5 Asian ☐ 50 Other (*specify*): _____ ☐ 88 None reported ☐ 99 Unknown
12. What additional race, beyond what was indicated above in questions 10 and 11, does subject report?	☐ 1 White ☐ 2 Black or African American ☐ 3 American Indian or Alaska Native ☐ 4 Native Hawaiian or Other Pacific Islander	☐ 5 Asian ☐ 50 Other (*specify*): _____ ☐ 88 None reported ☐ 99 Unknown

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _

NOTE: This form is to be completed by intake interviewer per ADC scheduling records, subject interview, medical records, and proxy informant report (as needed). For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A1. Check only one box per question.

ADC Visit #: _ _ _

13. Subject's primary language:	☐ 1 English ☐ 2 Spanish ☐ 3 Mandarin ☐ 4 Cantonese ☐ 5 Russian	☐ 6 Japanese ☐ 8 Other primary language (*specify*): _____ ☐ 9 Unknown
14. Subject's years of education (report achieved level using the codes below; if an attempted level is not completed, enter the number of years attended). High school/GED = 12; Bachelors degree = 16; Master's degree = 18; Doctorate = 20 years:	_ _ (*99 = Unknown*)	
15. What is the subject's living situation?	☐ 1 Lives alone ☐ 2 Lives with spouse or partner ☐ 3 Lives with relative or friend	☐ 4 Lives with group ☐ 5 Other (*specify*): _____ ☐ 9 Unknown
16. What is the subject's level of independence?	☐ 1 Able to live independently ☐ 2 Requires some assistance with complex activities	☐ 3 Requires some assistance with basic activities ☐ 4 Completely dependent ☐ 9 Unknown
17. What is the subject's primary type of residence?	☐ 1 Single family residence ☐ 2 Retirement community ☐ 3 Assisted living/ boarding home/adult family home	☐ 4 Skilled nursing facility/ nursing home ☐ 5 Other (*specify*): _____ ☐ 9 Unknown
18. Subject's primary residence zip code (first 3 digits):	_ _ _ (*leave blank if unknown*)	
19. Subject's current marital status:	☐ 1 Married ☐ 2 Widowed ☐ 3 Divorced ☐ 4 Separated	☐ 5 Never married ☐ 6 Living as married ☐ 8 Other (*specify*): _____ ☐ 9 Unknown
20. Is the subject left- or right-handed (for example, which hand would s/he normally use to write or throw a ball)?	☐ 1 Left-handed ☐ 2 Right-handed	☐ 3 Ambidextrous ☐ 9 Unknown

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form A2: Informant Demographics

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by intake interviewer per informant's report. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A2. Check only one box per question.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

1. Informant's month/year of birth:	__ __/__ __ __ __ *(99/9999 = Unknown)*	
2. Informant's sex:	☐ 1 Male	☐ 2 Female

3. Does the informant report being of Hispanic/Latino ethnicity (i.e., having origins from a mainly Spanish-speaking Latin American country), regardless of race?	☐ 1 Yes	☐ 0 No ☐ 9 Unknown
3a. If yes, what are the informant's reported origins?	☐ 1 Mexican/Chicano/ Mexican-American ☐ 2 Puerto Rican ☐ 3 Cuban ☐ 4 Dominican	☐ 5 Central American ☐ 6 South American ☐ 50 Other (*specify*): _____ ☐ 99 Unknown

4. What does informant report as his/her race?	☐ 1 White ☐ 2 Black or African American ☐ 3 American Indian or Alaska Native	☐ 4 Native Hawaiian or Other Pacific Islander ☐ 5 Asian ☐ 50 Other (*specify*): _____ ☐ 99 Unknown
5. What additional race does informant report?	☐ 1 White ☐ 2 Black or African American ☐ 3 American Indian or Alaska Native ☐ 4 Native Hawaiian or Other Pacific Islander	☐ 5 Asian ☐ 50 Other (*specify*): _____ ☐ 88 None reported ☐ 99 Unknown

Center: 31 ADC Subject ID: Form Date: / /

NOTE: This form is to be completed by intake interviewer per informant's report. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A2. Check only one box per question.

ADC Visit #:__ __ __

6. What additional race, beyond what was indicated above in questions 4 and 5, does informant report?

☐ 1 White
☐ 2 Black or African American
☐ 3 American Indian or Alaska Native
☐ 4 Native Hawaiian or Other Pacific Islander
☐ 5 Asian
☐ 50 Other (*specify*): _____
☐ 88 None reported
☐ 99 Unknown

7. Informant's years of education (report achieved level using the codes below; if an attempted level is not completed, enter the number of years attended). High school/GED = 12; Bachelors degree = 16; Master's degree – 18; Doctorate – 20 years: __ __ (*99 – Unknown*)

8. What is informant's relationship to subject?

☐ 1 Spouse/partner
☐ 2 Child
☐ 3 Sibling
☐ 4 Other relative
☐ 5 Friend/neighbor
☐ 6 Paid caregiver/provider
☐ 7 Other (*specify*): _____

9. Does the informant live with the subject?

☐ 1 Yes (*if yes, skip to #10*)
☐ 0 No

9a. If no, approximate frequency of in-person visits:

☐ 1 Daily
☐ 2 At least 3x/week
☐ 3 Weekly
☐ 4 At least 3x/month
☐ 5 Monthly
☐ 6 Less than once a month

9b. If no, approximate frequency of telephone contact:

☐ 1 Daily
☐ 2 At least 3x/week
☐ 3 Weekly
☐ 4 At least 3x/month
☐ 5 Monthly
☐ 6 Less than once a month

10. Is there a question about the informant's reliability?

☐ 1 Yes
☐ 0 No

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form A3: Subject Family History

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by intake interviewer per subject/informant report. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A3.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

For the following questions:

Dementia refers to progressive loss of memory and cognition, and is often described as senility, dementia, Alzheimer's Disease, hardening of the arteries, or other causes that compromised the subject's social or occupational functioning and from which they did not recover.

Age at onset refers to the age at which dementia symptoms began, not the age at which the diagnosis was made.

Please consider blood relatives only.

PARENTS:

	a. Year of birth (9999=unknown)	b. Is the parent still living? Yes	No	Unknown	c. If deceased, indicate year of death (9999=unknown)	d. Does/did this parent have dementia (defined above), as indicated by symptoms, history or diagnosis? Yes	No	Unknown	e. If yes, indicate age at onset (999=unknown)
1. Mother	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __
2. Father	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __

SIBLINGS:

3. Is the subject a twin? ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

3a. If yes, indicate type: ☐ 1 Monozygotic (i.e., identical) ☐ 2 Dizygotic (i.e., fraternal) ☐ 9 Unknown

4. How many full siblings did the subject have? (99 = Unknown) __ __

5. For all full siblings, indicate the following:

	5a. Year of birth (9999=unknown)	5b. Is the sibling still living? Yes	No	Unknown	5c. If deceased, indicate year of death (9999=unknown)	5d. Does/did this sibling have dementia (defined above), as indicated by symptoms, history or diagnosis? Yes	No	Unknown	5e. If yes, indicate age at onset (999=unknown)
Sibling 1	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __
Sibling 2	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __
Sibling 3	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by intake interviewer per subject/informant report. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A3..

ADC Visit #:_ _ _

SIBLINGS: *(continued)*	5a. **Year of birth** *(9999=unknown)*	5b. **Is the sibling still living?** Yes	No	Unknown	5c. **If deceased, indicate year of death** *(9999=unknown)*	5d. **Does/did this sibling have dementia (defined above), as indicated by symptoms, history or diagnosis?** Yes	No	Unknown	5e. **If yes, indicate age at onset** *(999=unknown)*
Sibling 4	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 5	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 6	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 7	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 8	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 10	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 11	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 12	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 13	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 14	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 15	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 16	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 17	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 18	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 19	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Sibling 20	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by intake interviewer per subject/informant report. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A3..

ADC Visit #:_ _ _

CHILDREN:

6. How many biological children did the subject have? *(99 = Unknown)* _ _

7. For all biological children, indicate the following:

	7a. Year of birth *(9999=unknown)*	7b. Is the child still living? Yes	No	Unknown	7c. If deceased, indicate year of death *(9999=unknown)*	7d. Does/did this child have dementia (defined above), as indicated by symptoms, history or diagnosis? Yes	No	Unknown	7e. If yes, indicate age at onset *(999=unknown)*
Child 1	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 2	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 3	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 4	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 5	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 6	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 7	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 8	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 10	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 11	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 12	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 13	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 14	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _
Child 15	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _ _	☐ 1	☐ 0	☐ 9	_ _ _

NOTE: This form is to be completed by intake interviewer per subject/informant report. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A3..

ADC Visit #:__ __ __

OTHER DEMENTED RELATIVES:

8. Number of "other demented relatives" (cousins, aunts, uncles, grandparents, half siblings), as indicated by symptoms, history or diagnosis. *(99 = Unknown)* __ __

9. For all "other demented relatives" (cousins, aunts, uncles, grandparents, half siblings), indicate the following:

	9a. **Year of birth** *(9999=unknown)*	9b. **Is the relative still living?** Yes	No	Unknown	9c. **If deceased, indicate year of death** *(9999=unknown)*	9d. **Indicate age at onset** *(999=unknown)*
Relative 1	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 2	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 3	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 4	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 5	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 6	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 7	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 8	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 9	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 10	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 11	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 12	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 13	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 14	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __
Relative 15	__ __ __ __	☐ 1	☐ 0	☐ 9	__ __ __ __	__ __ __

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website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B7: Functional Assessment – Functional Assessment Questionnaire (FAQ[1])

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _ ADC Visit #:_ _ _

NOTE: This form is to be completed by the clinician or other trained health professional, based on information provided by informant. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B7. Indicate the level of performance for each activity by circling the one appropriate response.

Examiner's initials:_ _ _

PID:
Visit:

In the past four weeks, did the subject have any difficulty or need help with:	Not applicable (e.g., never did)	Normal	Has difficulty, but does by self	Requires assistance	Dependent
1. Writing checks, paying bills, or balancing a checkbook.	8	0	1	2	3
2. Assembling tax records, business affairs, or other papers.	8	0	1	2	3
3. Shopping alone for clothes, household necessities, or groceries.	8	0	1	2	3
4. Playing a game of skill such as bridge or chess, working on a hobby.	8	0	1	2	3
5. Heating water, making a cup of coffee, turning off the stove.	8	0	1	2	3
6. Preparing a balanced meal.	8	0	1	2	3
7. Keeping track of current events.	8	0	1	2	3
8. Paying attention to and understanding a TV program, book, or magazine.	8	0	1	2	3
9. Remembering appointments, family occasions, holidays, medications.	8	0	1	2	3
10. Traveling out of the neighborhood, driving, or arranging to take public transportation.	8	0	1	2	3

[1] Pfeffer RI, Kurosaki TT, Harrah CH, et al. Measurement of functional activities of older adults in the community. *J Gerontol* 37:323-9, 1982.

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B5: Behavioral Assessment – Neuropsychiatric Inventory Questionnaire (NPI-Q[1])

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _ ADC Visit #:_ _ _

NOTE: This form is to be completed by the clinician or other trained health professional per informant interview, as described by the training video. (This is not to be completed by the subject as a paper-and-pencil self-report.) For information regarding NPI-Q Interviewer Certification, see UDS Coding Guidebook for Initial Visit Packet, Form B5. Check only one box for each category of response. Examiner's initials:_ _ _

Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no".

For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient):
1 = Mild (noticeable, but not a significant change)
2 = Moderate (significant, but not a dramatic change)
3 = Severe (very marked or prominent; a dramatic change)

1. NPI informant: ☐ 1 Spouse ☐ 2 Child ☐ 3 Other (*specify*): _____

	Yes	No	Severity
2. DELUSIONS: Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?	2a.	☐ 1	☐ 0	2b. ☐ 1 ☐ 2 ☐ 3
3. HALLUCINATIONS: Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?	3a.	☐ 1	☐ 0	3b. ☐ 1 ☐ 2 ☐ 3
4. AGITATION OR AGGRESSION: Is the patient stubborn and resistive to help from others?	4a.	☐ 1	☐ 0	4b. ☐ 1 ☐ 2 ☐ 3
5. DEPRESSION OR DYSPHORIA: Does the patient act as if he or she is sad or in low spirits? Does he or she cry?	5a.	☐ 1	☐ 0	5b. ☐ 1 ☐ 2 ☐ 3
6. ANXIETY: Does the patient become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?	6a.	☐ 1	☐ 0	6b. ☐ 1 ☐ 2 ☐ 3

PID:
Visit:

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Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _ ADC Visit #:_ _ _

NOTE: This form is to be completed by the clinician or other trained health professional per informant interview, as described by the training video. (This is not to be completed by the subject as a paper-and-pencil self-report.) For information regarding NPI-Q Interviewer Certification, see UDS Coding Guidebook for Initial Visit Packet, Form B5. Check only one box for each category of response.

Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no".

For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient):
1 = Mild (noticeable, but not a significant change)
2 = Moderate (significant, but not a dramatic change)
3 = Severe (very marked or prominent; a dramatic change)

	Yes	No	Severity
7. ELATION OR EUPHORIA: Does the patient appear to feel too good or act excessively happy?	7a. ☐ 1	☐ 0	7b. ☐ 1 ☐ 2 ☐ 3
8. APATHY OR INDIFFERENCE: Does the patient seem less interested in his or her usual activities and in the activities and plans of others?	8a. ☐ 1	☐ 0	8b. ☐ 1 ☐ 2 ☐ 3
9. DISINHIBITION: Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings?	9a. ☐ 1	☐ 0	9b. ☐ 1 ☐ 2 ☐ 3
10. IRRITABILITY OR LABILITY: Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?	10a. ☐ 1	☐ 0	10b. ☐ 1 ☐ 2 ☐ 3
11. MOTOR DISTURBANCE: Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?	11a. ☐ 1	☐ 0	11b. ☐ 1 ☐ 2 ☐ 3
12. NIGHTTIME BEHAVIORS: Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?	12a. ☐ 1	☐ 0	12b. ☐ 1 ☐ 2 ☐ 3
13. APPETITE AND EATING: Has the patient lost or gained weight, or had a change in the food he or she likes?	13a. ☐ 1	☐ 0	13b. ☐ 1 ☐ 2 ☐ 3

PID:
Visit:

History of Present Condition (interview)

MEMORY COMPLAINT / AGE OF ONSET:

	Yes	No	Relative to previously attained abilities:
1)	–	£	Does the subject report a decline in memory?
2)	–	£	Does the informant report a decline in subject's memory?

3) ___ ___ ___ (999 = Unknown) (888 = N/A) At what age did the cognitive decline, memory or non-memory abilities, begin (based upon the clinician's assessment)?

COGNITIVE SYMPTOMS:
Indicate whether the subject currently is impaired meaningfully, relative to previously attained abilities, in the following cognitive domains or has fluctuating cognition:

	Current (w/in 4 weeks)			Has been present since the onset of disorder				Date onset (mm / yyyy)	Onset (circle below)	Course (circle below)
	Yes (1)	No (0)	Unknown (9)	Yes (1)	No (0)	Unknown (9)	N/A (8)	99 – Unk mm 9999 – Unk yyyy	1 - Gradually 2 - Suddenly 3 - Unclear 4 - Undetermined	1 - Gradually 2 - Stepwise / Fluctuating 3 - Improved 4 - No Change 5 - Undetermined
4a) Memory (For example, does s/he forget conversations and/or dates; repeat questions and/or statements; misplace more than usual; forget names of people s/he knows well?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
4b) Judgment and problem-solving (For example, does s/he have trouble handling money (tips); paying bills; shopping; preparing meals; handling appliances; handling medications; driving?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
4c) Language (For example, does s/he have hesitant speech; have trouble finding words; use inappropriate words without self-correction?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
4d) Visuospatial function (Difficulty interpreting visual stimuli and finding his/her way around.)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
4e) Getting lost easily	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
4f) Attention / concentration (For example, does the subject have a short attention span or ability to concentrate? Is s/he easily distracted?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5

History of Present Condition (interview)

History of Present Condition (interview)

COGNITIVE SYMPTOMS:
Indicate whether the subject currently is impaired meaningfully, relative to previously attained abilities, in the following cognitive domains or has fluctuating cognition:

	Current (w/in 4 weeks)			Has been present since the onset of disorder				Date onset (mm / yyyy)	Onset (circle below)	Course (circle below)
	Yes (1)	No (0)	Unknown (9)	Yes (1)	No (0)	Unknown (9)	N/A (8)	99 – Unk mm 9999 – Unk yyyy	1 - Gradually 2 - Suddenly 3 - Unclear 4 - Undetermined	1 - Gradually 2 - Stepwise / Fluctuating 3 - Improved 4 - No Change 5 - Undetermined
4g) Fluctuating cognition (Does s/he have pronounced variation in attention and alertness, noticeably over hours or days? For example, long periods of staring into space or lapses, or times when his/her ideas have a disorganized flow.)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
4h) Disorientation to person, place or time	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
4i) Other (*If yes, then specify*): _____	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5

5) Indicate the predominant symptom which was first recognized as a decline in the subject's cognition:

- £ 1. Memory
- £ 2. Judgment and problem solving
- £ 3. Language
- £ 4. Visuospatial function
- £ 5. Attention / concentration
- £ 6. Other: _____
- £ 7. Fluctuating cognition
- £ 88. N/A
- £ 99. Unknown

6) Mode of onset of cognitive symptoms:

- £ 1. Gradual (> 6 months)
- £ 2. Subacute (≤ 6 months)
- £ 3. Abrupt (within days)
- £ 4. Other: _____
- £ 88. N/A
- £ 99. Unknown

History of Present Condition (interview)

History of Present Condition (interview)

BEHAVIOR SYMPTOMS: Indicate whether the subject currently manifests the following behavioral symptoms.	Current (w/in 4 weeks)			Has been present since the onset of disorder				Date onset (mm / yyyy) 99 – Unk mm 9999 – Unk yyyy	Onset (circle below) 1 - Gradually 2 - Suddenly 3 - Unclear 4 - Undetermined	Course (circle below) 1 - Gradually 2 - Stepwise / Fluctuating 3 - Improved 4 - No Change 5 - Undetermined
	Yes (1)	No (0)	Unknown (9)	Yes (1)	No (0)	Unknown (9)	N/A (8)			
7a) Apathy / withdrawal (Has the subject lost interest in or displayed a reduced ability to initiate usual activities and social interaction, such as conversing with family and/or friends?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7b) Depression (Has the subject seemed depressed for more than two weeks at a time; e.g., loss of interest or pleasure in nearly all activities; sadness, hopelessness, loss of appetite, fatigue?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7c) Psychosis 7c1) Visual hallucination	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7c2) Auditory hallucinations	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7c3) Abnormal/false/delusional beliefs	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7d) Disinhibition (Does the subject use inappropriate coarse language or exhibit inappropriate speech or behaviors in public or in the home? Does s/he talk personally to strangers or have disregard for personal hygiene?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7e) Irritability (Does the subject overreact, such as shouting at family members or others?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7f) Agitation (Does the subject have trouble sitting still; does s/he shout, hit, and/or kick?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7g) Personality change (Does the subject exhibit bizarre behavior or behavior uncharacteristic of the subject, such as unusual collecting, suspiciousness [without delusions], unusual dress, or dietary changes? Does the subject fail to take other's feelings into account?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5

History of Present Condition (interview)

History of Present Condition (interview)

BEHAVIOR SYMPTOMS: Indicate whether the subject currently manifests the following behavioral symptoms.	Current (w/in 4 weeks) Yes (1)	No (0)	Unknown (9)	Has been present since the onset of disorder Yes (1)	No (0)	Unknown (9)	N/A (8)	Date onset (mm / yyyy) 99 – Unk mm 9999 – Unk yyyy	Onset (circle below) 1 - Gradually 2 - Suddenly 3 - Unclear 4 - Undetermined	Course (circle below) 1 - Gradually 2 - Stepwise / Fluctuating 3 - Improved 4 - No Change 5 - Undetermined
7h) REM sleep behavior disorder (Does the subject appear to act out his/her dreams while sleeping (e.g., punch or flail their arms, shout or scream?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7i) Anxiety (Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
7j) Other (*If yes, then specify*): _____	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5

8) Indicate the predominant symptom which was first recognized as a decline in the subject's behavior:

£ 1. Apathy/withdrawal
£ 2. Depression
£ 3. Psychosis
£ 4. Disinhibition
£ 5. Irritability
£ 6. Agitation
£ 7. Personality Change
£ 8. Other: _____
£ 9. REM sleep behavior disorder
£ 88. N/A
£ 99. Unknown

9) Mode of onset of behavioral symptoms:

£ 1. Gradual (> 6 months)
£ 2. Subacute (≤ 6 months)
£ 3. Abrupt (within days)
£ 4. Other: _____
£ 88. N/A
£ 99. Unknown

History of Present Condition (interview)

History of Present Condition (interview)

MOTOR SYMPTOMS: Indicate where the subject currently has the following motor symptoms:	Current (w/in 4 weeks) Yes (1)	No (0)	Unknown (9)	Has been present since the onset of disorder Yes (1)	No (0)	Unknown (9)	NA (8)	Date onset (mm / yyyy) 99 – Unk mm 9999 – Unk yyyy	Onset (circle below) 1 - Gradually 2 - Suddenly 3 - Unclear 4 - Undetermined	Course (circle below) 1 - Gradually 2 - Stepwise / Fluctuating 3 - Improved 4 - No Change 5 - Undetermined
10a) Gait disorder (Has the subject's walking changed, not specifically due to arthritis or an injury? Is s/he unsteady, or does s/he shuffle when walking, have little or no arm-swing, or drag a foot?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
10b) Falls (Does the subject fall more than usual?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
10c) Tremor (Has the subject had rhythmic shaking, especially in the hands, arms, legs, head, mouth, or tongue?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5
10d) Slowness (Has the subject noticeably slowed down in walking or moving or handwriting, other than due to an injury or illness? Has his/her facial expression changed, or become more "wooden" or masked and unexpressive?)	–	£	•	–	£	•	∇	___ /_____	1 2 3 4	1 2 3 4 5

11) Indicate the predominant symptom which was first recognized as a decline in the subject's motor symptoms:

£ 1. Gait Disorder
£ 2. Falls
£ 3. Tremor
£ 4. Slowness
£ 88. N/A
£ 99. Unknown

12) Mode of onset of motor symptoms:

£ 1. Gradual (> 6 months)
£ 2. Subacute (≤ 6 months)
£ 3. Abrupt (within days)
£ 4. Other: _____
£ 88. N/A
£ 99. Unknown

History of Present Condition (interview)

History of Present Condition (interview)

13) Course of overall cognitive / behavioral / motor syndrome:

£ 1. Gradually progressive
£ 2. Stepwise
£ 3. Static / Unchanging
£ 4. Fluctuating
£ 5. Improved
£ 88. N/A
£ 9. Unknown

14) Indicate the predominant domain which was first recognized as changed in the subject:

£ 1. Cognition
£ 2. Behavior
£ 3. Motor function
£ 4. Unknown
£ 88. N/A

15) ¯ Yes £ No Has the subject ever been diagnosed with Dementia?

IF YES

15a) ____ / _____ **Date of Dementia Diagnosis**

15b) ____ / _____ **Date of Initial Symptom of Onset**

Comments:

History of Present Condition (interview)

List of Medications and Supplements:

Drug Name	# Per Dose	Dose	Unit Code	Freq. Code	Route Code	Mo-Year Started (if unknown enter 9's)	Reason for Starting	Multum Code
						_ _ - _ _ _ _		
						_ _ - _ _ _ _		
						_ _ - _ _ _ _		
						_ _ - _ _ _ _		
						_ _ - _ _ _ _		
						_ _ - _ _ _ _		
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						_ _ - _ _ _ _		

Drug Code:
From
Multum DB

Frequency Code:
1- QD, once a day
2- BID, twice a day
3- TID, three times a day
4- QID, four times a day
5- QHS, once a day @ bedtime
6- PRN, as needed or occasionally

Unit Code:
1- mg.
2- cc or ml
3- i.u.
4- other
5- unspecified

Route Code:
1- po, by mouth
2- topical
3- inhaled
4- injected
5- other

Multum
Entry Date: _____/_____/_____

Entry By
(initials): _____

Medication List (time of visit)

Completed By (Initials) _____

Date _____

Page __ of __

Name:

PID:

Visit:

phone: (206) 543-8637; fax: (206) 616-5927
e-mail: naccmail@u.washington.edu
website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet
Form A4: Subject Medications

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician or ADC staff. Record ALL medications (prescription, non-prescription, and vitamin/supplements) taken by the subject within the past two weeks.

ADC Visit #:_ _ _

If a medication is not one of the 100 drugs listed below, specify the drug or brand name and determine its drugID by using the Lookup Tool on the NACC website at https://www.alz.washington.edu/NONMEMBER/UDS/DrugCodeLookUp.html.

Examiner's initials:_ _ _

Is the subject currently taking any medications? ☐ Yes ☐ No

	Medication Name	drugID
☐	acetaminophen (Anacin, Tempra, Tylenol)	d00049
☐	acetaminophen-hydrocodone (Vicodin)	d03428
☐	albuterol (Proventil, Ventolin, Volmax)	d00749
☐	alendronate (Fosamax)	d03849
☐	allopurinol (Aloprim, Lopurin, Zyloprim)	d00023
☐	alprazolam (Niravam, Xanax)	d00168
☐	amitriptyline (Elavil, Endep, Vanatrip)	d00146
☐	amlodipine (Norvasc)	d00689
☐	ascorbic acid (C Complex, Vitamin C)	d00426
☐	aspirin	d00170
☐	atenolol (Senormin, Tenormin)	d00004
☐	atorvastatin (Lipitor)	d04105
☐	benazepril (Lotensin)	d00730
☐	bupropion (Budeprion, Wellbutrin, Zyban)	d00181
☐	calcium acetate (Calphron, PhosLo)	d03689
☐	calcium carbonate (Rolaids, Tums)	d00425
☐	calcium-vitamin D (Dical-D, O-Cal-D)	d03137
☐	carbidopa-levodopa (Atamet, Sinemet)	d03473
☐	celecoxib (Celebrex)	d04380
☐	citalopram (Celexa)	d04332
☐	clonazepam (Klonopin)	d00197
☐	clopidogrel (Plavix)	d04258
☐	conjugated estrogens (Cenestin, Premarin)	d00541
☐	conj. estrog.-medroxyprogesterone (Prempro)	d03819

	Medication Name	drugID
☐	cyanocobalamin (Neuroforte-R, Vitamin B12)	d00413
☐	digoxin (Digitek, Lanoxin)	d00210
☐	diltiazem (Cardizem, Tiazac)	d00045
☐	divalproex sodium (Depakote)	d03833
☐	docusate (Calcium Stool Softener, Dioctyl SS)	d01021
☐	donepezil (Aricept)	d04099
☐	enalapril (Vasotec)	d00013
☐	ergocalciferol (Calciferol, Drisdol, Vitamin D)	d03128
☐	escitalopram (Lexapro)	d04812
☐	estradiol (Estrace, Estrogel, Fempatch)	d00537
☐	famotidine (Mylanta AR, Pepcid)	d00141
☐	ferrous sulfate (FeroSul, Iron Supplement)	d03824
☐	fexofenadine (Allegra)	d04040
☐	finasteride (Propecia, Proscar)	d00563
☐	fluoxetine (Prozac)	d00236
☐	folic acid (Folic Acid)	d00241
☐	furosemide (Lasix)	d00070
☐	gabapentin (Neurontin)	d03182
☐	galantamine (Razadyne, Reminyl)	d04750
☐	glipizide (Glucotrol)	d00246
☐	glucosamine (Hydrochloride)	d04418
☐	glyburide (DiaBeta, Glycron, Micronase)	d00248
☐	hydrochlorothiazide (Esidrix, Hydrodiuril)	d00253
☐	hydrochlorothiazide-triamterene (Dyazide)	d03052

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician or ADC staff. Record ALL medications (prescription, non-prescription, and vitamin/supplements) taken by the subject within the past two weeks.

ADC Visit #:_ _ _

If a medication is not one of the 100 drugs listed below, specify the drug or brand name and determine its drugID by using the Lookup Tool on the NACC website at https://www.alz.washington.edu/NONMEMBER/UDS/DrugCodeLookUp.html.

Medication Name	drugID
☐ ibuprofen (Advil, Motrin, Nuprin)	d00015
☐ lansoprazole (Prevacid)	d03828
☐ latanoprost ophthalmic (Xalatan)	d04017
☐ levothyroxine (Levothroid, Levoxyl, Synthroid)	d00278
☐ lisinopril (Prinivil, Zestril)	d00732
☐ loratadine (Alavert, Claritin, Dimetapp, Tavist)	d03050
☐ lorazepam (Ativan)	d00149
☐ losartan (Cozaar)	d03821
☐ lovastatin (Altocor, Mevacor)	d00280
☐ medroxyprogesterone (Depo-Provera)	d00284
☐ memantine (Namenda)	d04899
☐ metformin (Glucophage, Riomet)	d03807
☐ metoprolol (Lopressor, Toprol-XL)	d00134
☐ mirtazapine (Remeron)	d04025
☐ multivitamin	d03140
☐ multivitamin with minerals	d03145
☐ naproxen (Aleve, Anaprox, Naprosyn)	d00019
☐ niacin (Niacor, Nico-400, Nicotinic Acid)	d00314
☐ nifedipine (Adalat, Procardia)	d00051
☐ nitroglycerin (Nitro-Bid, Nitro-Dur, Nitrostat)	d00321
☐ olanzapine (Zyprexa)	d04050
☐ omega-3 polyunsaturated fatty acids (Omacor)	d00497
☐ omeprazole (Prilosec)	d00325
☐ oxybutynin (Ditropan, Urotrol)	d00328
☐ pantoprazole (Protonix)	d04514
☐ paroxetine (Paxil, Paxil CR, Pexeva)	d03157
☐ phenytoin (Dilantin)	d00143
☐ potassium chloride (K-Dur 10, K-Lor, Slow-K)	d00345
☐ pravastatin (Pravachol)	d00348
☐ prednisone (Deltasone, Orasone)	d00350
☐ psyllium (Fiberall, Metamucil)	d01018

Medication Name	drugID
☐ pyridoxine (Vitamin B6)	d00412
☐ quetiapine (Seroquel)	d04220
☐ rabeprazole (Aciphex)	d04448
☐ raloxifene (Evista)	d04261
☐ ranitidine (Zantac)	d00021
☐ risperidone (Risperdal)	d03180
☐ rivastigmine (Exelon)	d04537
☐ sertraline (Zoloft)	d00880
☐ simvastatin (Zocor)	d00746
☐ tamsulosin (Flomax)	d04121
☐ temazepam (Restoril)	d00384
☐ terazosin (Hytrin)	d00386
☐ tolterodine (Detrol)	d04294
☐ trazodone (Desyrel)	d00395
☐ trolamine salicylate topical (Analgesia Creme)	d03884
☐ valsartan (Diovan)	d04113
☐ venlafaxine (Effexor)	d03181
☐ verapamil (Calan, Isoptin, Verelan)	d00048
☐ vitamin E (Aquavite-E, Centrum Singles)	d00405
☐ warfarin (Coumadin, Jantoven)	d00022
☐ zolpidem (Ambien)	d00910
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _
☐ *Specify:*	d_ _ _ _ _

MEDICATION ALLERGIES

A.4.2

1. £ Yes £ No Does the subject have a medication allergy?

If yes, indicate which medications or classes below:

a. £ Yes £ No Penicillin
b. £ Yes £ No Cephalosporin
c. £ Yes £ No Sulfa
d. £ Yes £ No Codeine
e. £ Yes £ No Demerol
f. £ Yes £ No Morphine
g. £ Yes £ No Valium
h. £ Yes £ No Aspirin
i. £ Yes £ No Ibuprofen
j. £ Yes £ No Iodine
k. £ Yes £ No Other (List) _____

Comments:

NACC
National Alzheimer's Coordinating Center

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website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form A5: Subject Health History

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A5. Check only one box per question.

ADC Visit #:_ _ _

Examiner's initials:_ _ _

Record the presence or absence of a history of these conditions at this visit as determined by the clinician's best judgment, based on informant report, medical records, and/or observation.

1. Cardiovascular disease	Absent	Recent/Active	Remote/Inactive	Unknown
a. Heart attack/cardiac arrest	☐ 0	☐ 1	☐ 2	☐ 9
b. Atrial fibrillation	☐ 0	☐ 1	☐ 2	☐ 9
c. Angioplasty/endarterectomy/stent	☐ 0	☐ 1	☐ 2	☐ 9
d. Cardiac bypass procedure	☐ 0	☐ 1	☐ 2	☐ 9
e. Pacemaker	☐ 0	☐ 1	☐ 2	☐ 9
f. Congestive heart failure	☐ 0	☐ 1	☐ 2	☐ 9
g. Other (*specify*): _____	☐ 0	☐ 1	☐ 2	☐ 9

2. Cerebrovascular disease	Absent	Recent/Active	Remote/Inactive	Unknown
a. Stroke If recent/active or remote/inactive, indicate year(s) in which this occurred: (*9999 = Year unknown*)	☐ 0	☐ 1 1) _ _ _ _ 2) _ _ _ _ 4) 5)	☐ 2 3) _ _ _ _ 6)	☐ 9
b. Transient ischemic attack If recent/active or remote/inactive, indicate year(s) in which this occurred: (*9999 = Year unknown*)	☐ 0	☐ 1 1) _ _ _ _ 2) _ _ _ _ 4) _ _ _ _ 5) _ _ _ _	☐ 2 3) _ _ _ _ 6) _ _ _ _	☐ 9
c. Other (*specify*): _____	☐ 0	☐ 1	☐ 2	☐ 9

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A5. Check only one box per question.

ADC Visit #: _ _

3. Parkinsonian features	Absent	Recent/Active	Unknown
a. Parkinson's disease	☐ 0	☐ 1	☐ 9
If recent/active, indicate year of diagnosis: (*9999 = Year unknown*) _ _ _ _			
b. Other Parkinsonism disorder	☐ 0	☐ 1	☐ 9
If recent/active, indicate year of diagnosis: (*9999 = Year unknown*) _ _ _ _			

4. Other neurologic conditions	Absent	Recent/Active	Remote/Inactive	Unknown
a. Seizures	☐ 0	☐ 1	☐ 2	☐ 9
b. Traumatic brain injury				
1) with brief loss of consciousness (< 5 minutes)	☐ 0	☐ 1	☐ 2	☐ 9
2) with extended loss of consciousness (> 5 minutes)	☐ 0	☐ 1	☐ 2	☐ 9
3) with chronic deficit or dysfunction	☐ 0	☐ 1	☐ 2	☐ 9
c. Other (*specify*): _____	☐ 0	☐ 1	☐ 2	☐ 9

5. Medical/metabolic conditions	Absent	Recent/Active	Remote/Inactive	Unknown
a. Hypertension	☐ 0	☐ 1	☐ 2	☐ 9
b. Hypercholesterolemia	☐ 0	☐ 1	☐ 2	☐ 9
c. Diabetes	☐ 0	☐ 1	☐ 2	☐ 9
d. B12 deficiency	☐ 0	☐ 1	☐ 2	☐ 9
e. Thyroid disease	☐ 0	☐ 1	☐ 2	☐ 9
f. Incontinence – urinary	☐ 0	☐ 1	☐ 2	☐ 9
g. Incontinence – bowel	☐ 0	☐ 1	☐ 2	☐ 9

Center: 31 ADC Subject ID: _____ Form Date: __/__/____

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form A5. Check only one box per question.

ADC Visit #: ____

6. Depression	No	Yes	Unknown
a. Active within past 2 years	☐ 0	☐ 1	☐ 9
b. Other episodes (prior to 2 years)	☐ 0	☐ 1	☐ 9

7. Substance abuse and psychiatric disorders

a. Substance abuse alcohol	Absent	Recent/Active	Remote/Inactive	Unknown
1) Clinically significant impairment occurring over a 12-month period manifested in one of the following: work, driving, legal or social.	☐ 0	☐ 1	☐ 2	☐ 9

b. Cigarette smoking history	No	Yes	Unknown
1) Has subject smoked within last 30 days?	☐ 0	☐ 1	☐ 9
2) Has subject smoked more than 100 cigarettes in his/her life?	☐ 0	☐ 1	☐ 9

3) Total years smoked: *(88 = N/A; 99 = Unknown)* __ __

4) Average number of packs/day smoked:

☐ 1 1 cigarette – < ½ pack ☐ 4 1½ – < 2 packs ☐ 9 Unknown
☐ 2 ½ – < 1 pack ☐ 5 ≥ 2 packs
☐ 3 1 – < 1½ pack ☐ 8 N/A

5) If subject quit smoking, specify age when last smoked (i.e., quit):
(888 = N/A; 999 = Unknown) __ __ __

c. Other abused substances	Absent	Recent/Active	Remote/Inactive	Unknown
1) Clinically significant impairment occurring over a 12-month period manifested in one of the following: work, driving, legal or social.	☐ 0	☐ 1	☐ 2	☐ 9

If recent/active or remote/inactive, specify abused substance(s): _____

d. Psychiatric disorders	☐ 0	☐ 1	☐ 2	☐ 9

If recent/active or remote/inactive, specify disorder(s): _____

Medical History

Medical Conditions

	Absent	Recent/ Active	Remote/ Inactive	Not Determined	M/YYYY Onset Date	
Vascular						
1	£	–	•	£		**Angina (Chest pain)**
2	£	–	•	£		**Heart Attack / Cardiac Arrest**
3	£	–	•	£		**Hypertension (High Blood Pressure)**
4	£	–	•	£		**Hyperlipidemia (High cholesterol, LDL or Triglycerides)**
5	£	–	•	£		**Stroke** Years:_____
6	£	–	•	£		**TIA (Stroke like event <24hrs)** Years: _____
7	£	–	•	£		**Atrial Fibrillation (A certain heart rhythm problem)**
8	£	–	•	£		**Pacemaker**
Neurological						
9	£	–	•	£		**Idiopathic Parkinson's disease (Diagnosed** Year: _____**)**
10	£	–	•	£		**Head Trauma: a) £** (1)**LOC <5min £** (2)**LOC >5min £** (9)**ND**
11	£	–	•	£		**Seizure Disorder**
12	£	–	•	£		**Incontinence: a) £ Urine b) £ Feces**
13	£	–	•	£		**Falls (In last year mark active, otherwise mark inactive) a) Num of: ____**
14	£	–	•	£		**Other CNS disease (specify):**
Common Medical						
15	£	–	•	£		**Benign Prostatic Hypertrophy (BPH)**
16	£	–	•	£		**Sleep Apnea a) £ Yes £ No £ ND – Being Treated?**
17	£	–	•	£		**Thyroid**
18	£	–	•	£		**B12 Deficiency**
19	£	–	•	£		**Diabetes Mellitus**
Psychiatric						(Premorbid = Prior to onset of dementia)
20	£	–	•	£		**Psychotic Disorders a) £ Yes £ No £ ND – Premorbid Hx?**
21	£	–	•	£		**Depression (>2 mo.) a) £ Yes £ No £ ND - Medications?**
22	£	–	•	£		**Anxiety Disorders a) £ Yes £ No £ ND – Premorbid Hx?** **b) £ Yes £ No £ ND – Medications?**
Alcohol / Substance						
23	£	–	•	£		**Alcohol Abuse or Dependence**
24	£	–	•	£		**Substance related Disorders (Non-alcohol)**
Gastrointestinal						
25	£	–	•	£		**GI disease**
26	£	–	•	£		**Peptic Ulcer**
Sensory						
27	£	–	•	£		**Hearing Impairment**
28	£	–	•	£		**Visual Impairment (Non-Correctable)**
29	£	–	•	£		**Glaucoma**
30	£	–	•	£		**Macular Degeneration**
31	£	–	•	£		**Cataracts**
Use of Aids						
32	**£ Yes £ No - Wears Hearing Aids**					
33	**£ Yes £ No - Wears Glasses or Corrective Lens**					

Medical History

	Absent	Recent/ Active	Remote/ Inactive	Not Determined	MM/YYYY Onset Date	
Other Medical Conditions						
34	£	–	•	£		**Heart Valve Disease (mitral Valve prolapsed, Aortic Stenosis)**
35	£	–	•	£		**Congestive Heart Failure**
36	£	–	•	£		**Other Heart Conditions (specify):**
37	£	–	•	£		**Asthma, COPD or other respiratory insufficiency**
38	£	–	•	£		**Renal Insufficiency (Kidney problems)**
39	£	–	•	£		**Hepatic Insufficiency (Liver problems)**
40	£	–	•	£		**Osteoarthritis (Ordinary arthritis)**
41	£	–	•	£		**Rheumatoid arthritis / Lupus / Scleroderma**
42	£	–	•	£		**Cancer: Breast / Colon / GYN / Prostate / Melanoma / Other: _____**
43	£	–	•	£		**STD's**
43a	£	–	•	£		**Syphilis**
43b	£	–	•	£		**HIV**
43c	£	–	•	£		**Hepatitis B**
43d	£	–	•	£		**Hepatitis C**
44	£	–	•	£		**Other Medical:**

Surgeries

45	£	–	•	£		**Open Heart Surgery / Cardiac Bypass Procedure**
46	£	–	•	£		**Angioplasty / Endarterectomy / Stent**
47	£	–	•	£		**Hysterectomy / Oophorectomy**
48	£	–	•	£		**Other Surgeries:**

Hospitalizations

49 £ Yes £ No **Have you been ever been hospitalized, or since your last study evaluation in the last year?**

	Month/Year	Hospital	Reason

Medical History

Smoking History

50. £ Yes £ No – Has the subject ever smoked?

(If yes, please answer the following)

a) £ Yes £ No - Has the subject smoked in the last 30 days?

b) £ Yes £ No - Has the subject quit smoking?

1) __ __ __ - Age when stopped smoking *(999 = unknown)*

c) __ __ - Total years smoked *(99 = unknown)*

d) Check the average number of packs per day smoked

1) £ 1 cig < ½ pack
2) £ ½ to 1 ½ packs
3) £ 1 ½ to 2 packs
4) £ > 2 packs
9) £ Unable to remember / Not determined

Alcohol Use (Past Year)

51) £ Yes £ No - Does the subject currently use alcohol? (Yes - *Answer a-c below)*

a) Please specify the average number of each type of drink the subject has consumed in a typical day over the past year.

[1 drink is = to 1 oz. liquor, 4 oz. of wine, 12 oz. of beer]
[1 standard bottle of wine (750 ml) = 5 drinks]
[One mixed drink may contain from 1-3 or more standard drinks if it contains multiple liquors]
[a pint of hard liquor = 11 drinks; "a fifth" of hard liquor = 17 drinks]

<u># of Drinks Per Day</u> (99 = ND)

1) __ __ Hard Liquor
2) __ __ Wine
3) __ __ Beer

b) £ Yes £ No £ ND Has the subject consumed greater than 4 drinks (if female) or 5 drinks (if male) on any given occasion in the past year?

If Yes, how frequently has this occurred?

1) £ Daily
2) £ Weekly
3) £ Monthly
4) £ Less than monthly *(e.g. several times per year)*

c) In your opinion, has the subject's alcohol use resulted in any of the following changes over the past year?

1) £ Yes £ No £ ND - Increased confusion, memory loss or cognitive difficulties
2) £ Yes £ No £ ND - Personality changes such as increased irritability/agitation
3) £ Yes £ No £ ND - Loss of balance and/or increased falling

Past Alcohol Use

52) £ Yes £ No £ ND - Did the subject use alcohol in the previous 5 years?

(If yes, please answer the following)

a) On average, how much did the subject drink?

1. £ 0-7 drinks/week or about 1 drink/day
2. £ 8-14 drinks/week or about 2 drinks/day
3. £ 15-21 drinks/week or about 3 drinks/day
4. £ 22-28 drinks/week or about 4 drinks/day
5. £ Greater than 30 drinks/week or about 5 drinks/day

b) £ Yes £ No- Did the subject stop drinking? (*Yes - Answer the following)*

1) __ __ __ __ What year did the subject stop drinking? (4 digits)

Past Alcohol Abuse

53) £ Yes £ No £ ND - Does the subject have a history of alcohol abuse?

(e.g. passing out, DUIs, negative legal, social, or occupational consequences from drinking?)

NACC
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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B1: Evaluation Form – Physical

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B1.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

SUBJECT PHYSICAL MEASUREMENTS		
1. Subject height (inches):	*(99.9 = unknown)*	__ __ . __
2. Subject weight (lbs.):	*(999 = unknown)*	__ __ __
3. Subject blood pressure (sitting)	*(999/999 = unknown)*	__ __ __/__ __ __
4. Subject resting heart rate (pulse)	*(999 = unknown)*	__ __ __

ADDITIONAL PHYSICAL OBSERVATIONS	Yes	No	Unknown
5. Without corrective lenses, is the subject's vision functionally normal?	☐ 1	☐ 0	☐ 9
6. Does the subject usually wear corrective lenses?	☐ 1	☐ 0	☐ 9
6a. If yes, is the subject's vision functionally normal <u>with</u> corrective lenses?	☐ 1	☐ 0	☐ 9
7. Without a hearing aid(s), is the subject's hearing functionally normal?	☐ 1	☐ 0	☐ 9
8. Does the subject usually wear a hearing aid(s)?	☐ 1	☐ 0	☐ 9
8a. If yes, is the subject's hearing functionally normal <u>with</u> a hearing aid(s)?	☐ 1	☐ 0	☐ 9

General Physical

Pulse / Blood Pressure * - Required

Sitting: *1a) _____ 1a1) _____/_____

Standing: 1b) _____ 1b1) _____/_____

Supine: 1c) _____ 1c1)_____/_____

Visual Acuity LT RT

W/O Correction: 2a) 20/___ 2a1) 20/___

With Correction: 2b) 20/___ 2b1) 20/___

Both Eyes Together

*2c) 20/___ 2d) £ Yes £ No Corrective Lens Used

Height

*3a) __ __.__”

Weight

*3b) __ __ __ lbs

	WNL	ABN	ND	General
4.	£	_	•	General appearance
5.	£	_	•	Alert, NAD
6.	£	_	•	Well developed, nourished,
7.	£	_	•	Personal hygiene
				ENT
8.	£	_	•	Hearing intact bilaterally
				8a. £ Mild £ Mod £ Severe
(Complete the following for State assessment only)				
9.	£	_	•	External canal and TMs clear
10.	£	_	•	Palate, uvula, oropharynx pink, no lesions
11.	£	_	•	Nasal mucosa, septum, turbinate intact
				Head
12.	£	_	•	ATNC, no scars, lesions
13.	£	_	•	No sinus tenderness
				Eyes
14.	£	_	•	PERLA, sclera, conjunctiva intact,
15.	£	_	•	Normal fundi, no exudates, hemorrhage, nicking
				Neck
16.	£	_	•	Supple, free ROM w/o pain
17.	£	_	•	No thyroidmegaly or masses
18.	£	_	•	No carotid bruits
				Lymph nodes
19.	£	_	•	No cervical lymphadenopathy
20.	£	_	•	Other lymph nodes
				Lungs
21.	£	_	•	Expansion symmetrical, clear to auscultation
				Heart
22.	£	_	•	RRR
23.	£	_	•	No murmurs, rubs, gallops
				Abdomen
24.	£	_	•	Not distended, bowel sounds normal
25.	£	_	•	No masses, organomegaly
				Extremities
26.	£	_	•	No deformities, lesions
27.	£	_	•	No edema
28.	£	_	•	Varicosities
29.	£	_	•	Pulses +/=
				Skin
30.	£	_	•	Dry, intact, no lesions

Neuro Case Summary

Gender: M / F **Age: _____** **Race: _____** **Edu Yrs: _____**

Handedness: L / R / Both **Currently Working: Y / N** **Occupation: _____**

Current Driving: Y / N If NO: **Retired Year: _____**

Previous Evaluation: Y / N **Physician: _____** **Year Seen: _____**

Past Diagnosis: _____

HPI:

	Year of Onset	Mode of Onset			Course				New Symptom
Cognitive Symptoms		Grd	Sud	Uncl	Grd	St/Fl	Imp	NoCh	
Memory		£	¯	•	£	¯	•	∇	£
Judgement		£	¯	•	£	¯	•	∇	£
Language		£	¯	•	£	¯	•	∇	£
Visuospatial		£	¯	•	£	¯	•	∇	£
Getting Lost		£	¯	•	£	¯	•	∇	£
Attention/Concentration		£	¯	•	£	¯	•	∇	£
Fluctuating Cognition		£	¯	•	£	¯	•	∇	£
Disorientation		£	¯	•	£	¯	•	∇	£
Behavior Symptoms									
Apathy		£	¯	•	£	¯	•	∇	£
Depression		£	¯	•	£	¯	•	∇	£
Visual Hallucinations		£	¯	•	£	¯	•	∇	£
Auditory Hallucinations		£	¯	•	£	¯	•	∇	£
Delusional Beliefs		£	¯	•	£	¯	•	∇	£
Disinhibition		£	¯	•	£	¯	•	∇	£
Irritability		£	¯	•	£	¯	•	∇	£
Agitation		£	¯	•	£	¯	•	∇	£
Personality Change		£	¯	•	£	¯	•	∇	£
REM Sleep Disorder		£	¯	•	£	¯	•	∇	£
Anxiety		£	¯	•	£	¯	•	∇	£
Motor Symptoms									
Gait Disorder		£	¯	•	£	¯	•	∇	£
Falls		£	¯	•	£	¯	•	∇	£
Tremor		£	¯	•	£	¯	•	∇	£
Slowness		£	¯	•	£	¯	•	∇	£

Comments:

Neuro Case Summary

Neuro Case Summary (Cont.)

Family Hx: £ No Family History

Relationship	AD (Age)	Sen/Dem (Age)	PD	Stroke	Psych Ill	Depression	Age of Death
			£	£	£	£	
			£	£	£	£	
			£	£	£	£	
			£	£	£	£	

Medical Hx: £ No Significant Medical History

- £ Atrial Fibrillation
- £ CAD / Heart Attack
- £ Pacemaker
- £ Stroke / TIA
- £ Parkinson's
- £ Seizures
- £ Head Injuries
- £ Osteoarthritis
- £ Rheumatoid arthritis
- £ Hypertension
- £ Hyperlipidemia
- £ Diabetes
- £ Thyroid disease
- £ Asthma / COPD
- £ Liver problems
- £ Kidney problems
- £ Incontinence (Urine / BM)
- £ Sleep apnea

Sensory Problems

- £ Cataracts
- £ Glaucoma
- £ Macular degeneration
- £ Hearing impairment

£ Cancer: _____

Surgical Hx: £ No Significant Surgical History

_____ Date: _____
_____ Date: _____
_____ Date: _____

Habit Hx: £ No Significant Habit History

Alcohol

¯ Yes £ No Alcohol Abuse

¯ Yes £ No Current use

_____ Average per week

Tobacco

¯ Yes £ No Ever smoke

¯ Yes £ No Currently smoking

_____ Years smoked

_____ Average packs / day

_____ Age quit

Imaging (MRI/CT):

Labs:

ROS:

PE:

Neuro Case Summary (Cont.)

NACC
National Alzheimer's Coordinating Center

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website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B2: Evaluation Form – HIS and CVD

Center: 31 _____ ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician or other trained health professional. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B2.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

HACHINSKI ISCHEMIC SCORE [1]

Please complete the following scale using information obtained from history/physical/neurological exam and/or medical records. Circle the appropriate value to indicate if a specific item is present (characteristic of the patient) or absent.

	Present	Absent
1. Abrupt onset (re: cognitive status)	2	0
2. Stepwise deterioration (re: cognitive status)	1	0
3. Somatic complaints	1	0
4. Emotional incontinence	1	0
5. History or presence of hypertension	1	0
6. History of stroke	2	0
7. Focal neurological symptoms	2	0
8. Focal neurological signs	2	0
9. **Sum all circled answers for a Total Score:**	__ __	

[1] Rosen Modification of Hachinski Ischemic Score (*Ann Neurol* 7:486-488, 1980). Copyright© John Wiley & Sons, Inc. Reproduced by permission.

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician or other trained health professional. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B2.

ADC Visit #:_ _ _

CEREBROVASCULAR DISEASE	Yes	No	N/A
10. Using your best judgment, do you believe that cerebrovascular disease (CVD) is contributing to the cognitive impairment?	☐ 1	☐ 0	☐ 8
11. If there is a stroke, is there a temporal relationship between stroke and onset of cognitive impairment?	☐ 1	☐ 0	☐ 8
12. Is there imaging evidence which supports that CVD is contributing to the cognitive impairment?	☐ 1	☐ 0	☐ 8
12a. If yes, indicate which imaging evidence was found:			
1) Single strategic infarct	☐ 1	☐ 0	
2) Multiple infarcts	☐ 1	☐ 0	
3) Extensive white matter hyperintensity	☐ 1	☐ 0	
4) Other (*specify*): _____	☐ 1	☐ 0	

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B3: Evaluation Form – Unified Parkinson's Disease Rating Scale (UPDRS[1]) – Motor Exam

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician or other trained health professional. ADC Visit #: _ _ _
For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B3.Check only one box per question. Examiner's initials: _ _ _

1. Speech	☐ 0 Normal. ☐ 1 Slight loss of expression, diction and/or volume. ☐ 2 Monotone, slurred but understandable; moderately impaired.	☐ 3 Marked impairment, difficult to understand. ☐ 4 Unintelligible. ☐ 8 Untestable (*specify reason*): _____
2. Facial expression	☐ 0 Normal. ☐ 1 Minimal hypomimia, could be normal "poker face". ☐ 2 Slight but definitely abnormal diminution of facial expression.	☐ 3 Moderate hypomimia; lips parted some of the time. ☐ 4 Masked or fixed facies with severe or complete loss of facial expression; lips parted ¼ inches or more. ☐ 8 Untestable (*specify reason*): _____

3. Tremor at rest		
3a. Face, lips, chin	☐ 0 Absent. ☐ 1 Slight and infrequently present. ☐ 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	☐ 3 Moderate in amplitude and present most of the time. ☐ 4 Marked in amplitude and present most of the time. ☐ 8 Untestable (*specify reason*): _____
3b. Right hand	☐ 0 Absent. ☐ 1 Slight and infrequently present. ☐ 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	☐ 3 Moderate in amplitude and present most of the time. ☐ 4 Marked in amplitude and present most of the time. ☐ 8 Untestable (*specify reason*): _____

[1] Fahn S, Elton RL, UPDRS Development Committee. The Unified Parkinson's Disease Rating Scale. In Fahn S, Marsden CD, Calne DB, Goldstein M, eds. Recent developments in Parkinson's disease, Vol. 2. Florham Park, NJ: Macmillan Healthcare Information, 1987:153-163, 293-304. Reproduced by permission of the author.

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician or other trained health professional. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B3.Check only one box per question. ADC Visit #: __ __ __

3c. Left hand	☐ 0 Absent. ☐ 1 Slight and infrequently present. ☐ 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	☐ 3 Moderate in amplitude and present most of the time. ☐ 4 Marked in amplitude and present most of the time. ☐ 8 Untestable (*specify reason*): _____
3d. Right foot	☐ 0 Absent. ☐ 1 Slight and infrequently present. ☐ 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	☐ 3 Moderate in amplitude and present most of the time. ☐ 4 Marked in amplitude and present most of the time. ☐ 8 Untestable (*specify reason*): _____
3e. Left foot	☐ 0 Absent. ☐ 1 Slight and infrequently present. ☐ 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	☐ 3 Moderate in amplitude and present most of the time. ☐ 4 Marked in amplitude and present most of the time. ☐ 8 Untestable (*specify reason*): _____

4. Action or postural tremor of hands		
4a. Right hand	☐ 0 Absent. ☐ 1 Slight; present with action. ☐ 2 Moderate in amplitude, present with action.	☐ 3 Moderate in amplitude with posture holding as well as action. ☐ 4 Marked in amplitude; interferes with feeding. ☐ 8 Untestable (*specify reason*): _____
4b. Left hand	☐ 0 Absent. ☐ 1 Slight; present with action. ☐ 2 Moderate in amplitude, present with action.	☐ 3 Moderate in amplitude with posture holding as well as action. ☐ 4 Marked in amplitude; interferes with feeding. ☐ 8 Untestable (*specify reason*): _____

5. Rigidity (judged on passive movement of major joints with patient relaxed in sitting position; cogwheeling to be ignored)		
5a. Neck	☐ 0 Absent. ☐ 1 Slight or detectable only when activated by mirror or other movements. ☐ 2 Mild to moderate.	☐ 3 Marked, but full range of motion easily achieved. ☐ 4 Severe; range of motion achieved with difficulty. ☐ 8 Untestable (*specify reason*): _____

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician or other trained health professional. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B3.Check only one box per question. ADC Visit #: __ __ __

5b. Right upper extremity	☐ 0 Absent. ☐ 1 Slight or detectable only when activated by mirror or other movements. ☐ 2 Mild to moderate.	☐ 3 Marked, but full range of motion easily achieved. ☐ 4 Severe; range of motion achieved with difficulty. ☐ 8 Untestable (*specify reason*): _____
5c. Left upper extremity	☐ 0 Absent. ☐ 1 Slight or detectable only when activated by mirror or other movements. ☐ 2 Mild to moderate.	☐ 3 Marked, but full range of motion easily achieved. ☐ 4 Severe; range of motion achieved with difficulty. ☐ 8 Untestable (*specify reason*): _____
5d. Right lower extremity	☐ 0 Absent. ☐ 1 Slight or detectable only when activated by mirror or other movements. ☐ 2 Mild to moderate.	☐ 3 Marked, but full range of motion easily achieved. ☐ 4 Severe; range of motion achieved with difficulty. ☐ 8 Untestable (*specify reason*): _____
5e. Left lower extremity	☐ 0 Absent. ☐ 1 Slight or detectable only when activated by mirror or other movements. ☐ 2 Mild to moderate.	☐ 3 Marked, but full range of motion easily achieved. ☐ 4 Severe; range of motion achieved with difficulty. ☐ 8 Untestable (*specify reason*): _____

6. Finger taps (patient taps thumb with index finger in rapid succession)		
6a. Right hand	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*): _____
6b. Left hand	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*): _____

7. Hand movements (patient opens and closes hands in rapid succession)		
7a. Right hand	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*): _____

NOTE: This form is to be completed by the clinician or other trained health professional. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B3.Check only one box per question. ADC Visit #: __ __ __

7b. Left hand	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*): _____

8. Rapid alternating movements of hands (pronation-supination movements of hands, vertically and horizontally, with as large an amplitude as possible, both hands simultaneously)

8a. Right hand	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*): _____
8b. Left hand	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*): _____

9. Leg agility (patient taps heel on the ground in rapid succession, picking up entire leg; amplitude should be at least 3 inches)

9a. Right leg	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*):
9b. Left leg	☐ 0 Normal. ☐ 1 Mild slowing and/or reduction in amplitude. ☐ 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	☐ 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. ☐ 4 Can barely perform the task. ☐ 8 Untestable (*specify reason*): _____

NOTE: This form is to be completed by the clinician or other trained health professional. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B3.Check only one box per question. ADC Visit #: __ __ __

10. Arising from chair (patient attempts to rise from a straight-backed chair, with arms folded across chest)	☐ 0 Normal. ☐ 1 Slow; or may need more than one attempt. ☐ 2 Pushes self up from arms of seat.	☐ 3 Tends to fall back and may have to try more than one time, but can get up without help. ☐ 4 Unable to arise without help. ☐ 8 Untestable (*specify reason*):
11. Posture	☐ 0 Normal. ☐ 1 Not quite erect, slightly stooped posture; could be normal for older person. ☐ 2 Moderately stooped posture, definitely abnormal; can be slightly leaning to one side.	☐ 3 Severely stooped posture with kyphosis; can be moderately leaning to one side. ☐ 4 Marked flexion with extreme abnormality of posture. ☐ 8 Untestable (*specify reason*):
12. Gait	☐ 0 Normal. ☐ 1 Walks slowly; may shuffle with short steps, but no festination (hastening steps) or propulsion. ☐ 2 Walks with difficulty, but requires little or no assistance; may have some festination, short steps, or propulsion.	☐ 3 Severe disturbance of gait requiring assistance. ☐ 4 Cannot walk at all, even with assistance. ☐ 8 Untestable (*specify reason*):
13. Posture stability (response to sudden, strong posterior displacement produced by pull on shoulders while patient erect with eyes open and feet slightly apart; patient is prepared)	☐ 0 Normal erect. ☐ 1 Retropulsion, but recovers unaided. ☐ 2 Absence of postural response; would fall if not caught by examiner.	☐ 3 Very unstable, tends to lose balance spontaneously. ☐ 4 Unable to stand without assistance. ☐ 8 Untestable (*specify reason*):
14. Body bradykinesia and hypokinesia (combining slowness, hesitancy, decreased arm swing, small amplitude, and poverty of movement in general)	☐ 0 None. ☐ 1 Minimal slowness, giving movement a deliberate character; could be normal for some persons; possibly reduced amplitude. ☐ 2 Mild degree of slowness and poverty of movement which is definitely abnormal. Alternatively, some reduced amplitude.	☐ 3 Moderate slowness, poverty or small amplitude of movement. ☐ 4 Marked slowness, poverty or small amplitude of movement. ☐ 8 Untestable (*specify reason*):

Neurological Assessment

MENTAL STATUS (higher integrative functions) **Comments:**

	WNL	ABN	NT	
1.	£	—	•	**ALERTNESS (Note: Orientation measured by MMSE)**
1a.		Present —	Absent £	**DELIRIUM**
2.	£	—	•	**SPEECH (including language assessment)**
3.	£	—	•	**MOOD**
3a.		Present —	Absent £	**DEPRESSION**
4.	£	—	•	**JUDGEMENT**
5.	£	—	•	**INSIGHT**

CRANIAL NERVES **Comments:**

6. **OLFACTORY (CN I) (# correct 0-3) __4___**
NT = 4

Describe Abnormal Findings:

	WNL	ABN	NT		
7.	£	—	•	**CN II**	_____
8.	£	—	•	**CN III, IV, VI**	_____
9.	£	—	•	**CN V**	_____
10.	£	—	•	**CN VII**	_____
11.	£	—	•	**CN VIII**	
12.	£	—	•	**CN IX, X, XI, XII**	_____
13.	£	—	•	**Dysarthria**	_____

	WNL	ABN		NT	
14.	£	Right —	Left —	•	**Tongue Protrusion**_____
	Straight				

	WNL	ABN		NT	
		Mild	Severe		**Limitation** of Gaze
15.	£	—	—	•	**Vertical** _____
16.	£	—	—	•	**Horizontal** _____

Does subject have any of the following abnormalities?

	Absent/ Normal	Present/ Abnormal	NT	
17.	£	—	•	**Nystagmus** _____
18.	£	—	•	**Saccadic Smooth Pursuit** _____
19.	£	—	•	**Difficulty participating in Smooth Pursuit** _____
20.	£	—	•	**Masked facies** _____

Neurological Assessment

Neurological Assessment

Motor System

Deep Tendon Reflexes

	Right							Left						
	Normal					NT		Normal					NT	
	0	1	2	3	4	5		0	1	2	3	4	5	
21a.	– Absent	– Hypo	£	– Hyper	– Clonus	•	**Biceps**	21b.	– Absent	– Hypo	£	– Hyper	– Clonus	•
22a.	– Absent	– Hypo	£	– Hyper	– Clonus	•	**Triceps**	22b.	– Absent	– Hypo	£	– Hyper	– Clonus	•
23a.	– Absent	– Hypo	£	– Hyper	– Clonus	•	**Supinator**	23b.	– Absent	– Hypo	£	– Hyper	– Clonus	•
24a.	– Absent	– Hypo	£	– Hyper	– Clonus	•	**Patellar**	24b.	– Absent	– Hypo	£	– Hyper	– Clonus	•
25a.	– Absent	– Hypo	£	– Hyper	– Clonus	•	**Achilles**	25b.	– Absent	– Hypo	£	– Hyper	– Clonus	•

Pathological Reflexes

	Right				Left			
	Absent/ Normal	Present/ Abnormal	NT		Absent/ Normal	Present/ Abnormal	NT	
26a.	£	–	•	**Plantar Extension (Babinski)**	26b. £	–	•	
27a.	£	–	•	**Palmomental**	27b. £	–	•	
28a.	£	–	•	**Grasp**	28b. £	–	•	

	Absent/ Normal	Present/ Abnormal	NT	
29.	£	–	•	**Snout**

Neurological Assessment

Abnormal Movements

	Right: Absent/ Normal	Right: Present/ Abnormal	Right: NT	Upper extremities except where noted	Left: Absent/ Normal	Left: Present/ Abnormal	Left: NT	
30a. / 30b.	£	–	•	**Pronator Drift**	£	–	•	
31a. / 31b.	£	–	•	**Abnormal Posturing**	£	–	•	
32a. / 32b.	£	–	•	**Myoclonus**	£	–	•	
				Spastic Hypertonia				
33a. / 33b.	£	–	•	**Upper extremities**	£	–	•	
34a. / 34b.	£	–	•	**Lower extremities**	£	–	•	
35a. / 35b.	£	–	•	**Paramyotonia**	£	–	•	
36a. / 36b.	£	–	•	**Cogwheeling**	£	–	•	
37a. / 37b.	£	–	•	**Resting Tremors**	£	–	•	
38a. / 38b.	£	–	•	**Action Tremors**	£	–	•	
39a. / 39b.	£	–	•	**Postural Temors**	£	–	•	
40a. / 40b.	£	–	•	**Bradykinesia**	£	–	•	

41. £ – • **Praxis** _____

42. £ – • **Glabellar** _____

	Absent/ Normal	Present/ Abnormal	NT		
43.	£	–	•	**Dystonia**	_____

UMN Weakness

	Right: WNL						NT		Left: WNL						NT
	5	4	3	2	1	0	6		5	4	3	2	1	0	6
44a. / 44b.	£	–	–	–	–	–	•	**Upper extremities**	£	–	–	–	–	–	•
45a. / 45b.	£	–	–	–	–	–	•	**Lower extremities**	£	–	–	–	–	–	•

Neurological Assessment

Neurological Assessment

Sensory Evaluation

	Absent/ Normal	Present/ Abnormal	NT	
46.	£	–	•	**Romberg Sign**

	Right: Normal	Right: Decreased Mild	Right: Decreased Mod	Right: Decreased Severe	Right: NT		Left: Normal	Left: Decreased Mild	Left: Decreased Mod	Left: Decreased Severe	Left: NT
47a./47b.	£	–	–	–	•	**Face**	£	–	–	–	•
48a./48b.	£	–	–	–	•	**Arms** (Non-glove)	£	–	–	–	•
49a./49b.	£	–	–	–	•	**Legs** (Non-stocking)	£	–	–	–	•
50a./50b.	£	–	–	–	•	**Stocking Distribution**	£	–	–	–	•
51a./51b.	£	–	–	–	•	**Glove Distribution**	£	–	–	–	•
52a./52b.	£	–	–	–	•	**Vibrations**	£	–	–	–	•

Gait Evaluation

	Normal	ABN	NT	
53.	£	–	•	**Gait (If abnormal gait, complete the following)**

	Absent	ABN: Mild	ABN: Mod	ABN: Severe	NT	
a.	£	–	–	–	•	**Short steps**
b.	£	–	–	–	•	**Shuffle**
c.	£	–	–	–	•	**Lack of arm swing**
d.	£	–	–	–	•	**Circumduction**
e.	£	–	–	–	•	**Flexed / stooped posture**
f.	£	–	–	–	•	**Turns en bloc**
g.	£	–	–	–	•	**Wide-based**
h.	£	–	–	–	•	**Truncal instability**
i.	£	–	–	–	•	**Poor tandem**
j.	£	–	–	–	•	**Retropulsion**

If ABN retropulsion then (check all that apply):

Spontaneous	1. £ Yes	£ No	• NT
On turns	2. £ Yes	£ No	• NT
Sternal nudge	3. £ Yes	£ No	• NT

	Absent/ Normal	Present/ Abnormal	NT	
k.	£	–	•	Spastic

l. £ **Yes** £ **No** **Non-neurological/ Orthopedic**

If yes, describe.

Neurological Assessment

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website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B8: Evaluation – Physical/Neurological Exam Findings

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B8. Check only one box per question.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

PHYSICAL/NEUROLOGICAL EXAM FINDINGS	Yes	No	Unknown
1. Are all findings unremarkable (normal or normal for age)?	☐ 1	☐ 0	☐ 9
2. Are focal deficits present indicative of central nervous system disorder?	☐ 1	☐ 0	☐ 9
3. Is gait disorder present indicative of central nervous system disorder?	☐ 1	☐ 0	☐ 9
4. Are there eye movement abnormalities present indicative of central nervous system disorder?	☐ 1	☐ 0	☐ 9

MEDICAL ORDERS

Laboratory Tests Date Drawn:			Diagnostic Tests	
ANA ☐ Ordered ☐ Received	**Sed Rate** ☐ Ordered ☐ Received	**Urinalysis** ☐ Ordered ☐ Received	**MRI of the Brain w/ or w/o Contrast** ☐ Ordered ☐ Received ☐ Date: Facility:	**Chest X-Ray** ☐ Ordered ☐ Received ☐ Date: Facility:
CBC with diff. ☐ Ordered ☐ Received	**T4** ☐ Ordered ☐ Received	**MHATP** ☐ Ordered ☐ Received	**CT Scan of the Brain** ☐ Ordered ☐ Received ☐ Date: Facility:	**EKG** ☐ Ordered ☐ Received ☐ Date: Facility:
Chem. Panel ☐ Ordered ☐ Received	**TSH** ☐ Ordered ☐ Received	**Homocysteine** ☐ Ordered ☐ Received	**SPECT Scan** ☐ Ordered ☐ Received ☐ Date: Facility:	**Carotid Doppler** ☐ Ordered ☐ Received ☐ Date: Facility:
Folate ☐ Ordered ☐ Received	**B-12** ☐ Ordered ☐ Received	**Other:** ☐ Ordered ☐ Received	**EEG / EMG** ☐ Ordered ☐ Received ☐ Date: Facility:	**Other**: ☐ Ordered ☐ Received ☐ Date: Facility:
RPR ☐ Ordered ☐ **Received**				

Consultation:

Reason:

Additional Comments:

MEDICAL ORDERS

NACC
National Alzheimer's Coordinating Center

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website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form C1: MMSE and Neuropsychological Battery

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _

NOTE: This form is to be completed by ADC or clinic staff. For test administration and scoring, see UDS Coding Guidebook for Initial Visit Packet, Form C1.

ADC Visit #: _ _ _

Examiner's initials: _ _ _

KEY: If the subject cannot complete any of the following exams, please use the following codes for test scores (except for the Trail Making Test):

95 = Physical problem
96 = Cognitive/behavior problem
97 = Other problem
98 = Verbal refusal

1. Mini-Mental State Examination

1a. The administration of the MMSE was: ☐ 1 In ADC/clinic ☐ 2 In home ☐ 3 In person–other

1) Language of MMSE administration: ☐ 1 English ☐ 2 Spanish ☐ 3 Other (*specify*): _____

1b. Orientation subscale score

1) Time: _ _ (0–5) *see Key*

2) Place: _ _ (0–5) *see Key*

1c. Intersecting pentagon subscale score: _ _ (0–1) *see Key*

1d. Total MMSE score ~~(using D-L-R-O-W)~~ _ _ (0–30) *see Key*

2. The remainder of the battery (below) was administered: ☐ 1 In ADC/clinic ☐ 2 In home ☐ 3 In person–other

2a. Language of test administration: ☐ 1 English ☐ 2 Spanish ☐ 3 Other (*specify*): _____

3. Logical Memory 1A – Immediate

3a. If this test has been administered to the subject within the past 3 months, specify the date previously administered: _ _/_ _/_ _ _ _ (88/88/8888 = N/A)

1) Total score from the previous test administration: _ _ (0–25; *88 = N/A*)

3b. Total number of story units recalled from this current test administration: _ _ (0–25) *see Key*

4. Digit Span Forward

4a. Total number of trials correct prior to two consecutive errors at the same digit length: _ (0–12) *see Key*

4b. Digit span forward length: _ _ (0–8) *see Key*

NOTE: This form is to be completed by ADC or clinic staff. For test administration and scoring, see UDS Coding Guidebook for Initial Visit Packet, Form C1. ADC Visit #:__ __ __

5.	**Digit Span Backward**		
	5a. Total number of trials correct prior to two consecutive errors at the same digit length:	__ __	(0–12) *see Key*
	5b. Digit span backward length:	__ __	(0–7) *see Key*
6.	**Category Fluency**		
	6a. Animals – Total number of animals named in 60 seconds:	__ __	(0–77) *see Key*
	6b. Vegetables – Total number of vegetables named in 60 seconds:	__ __	(0–77) *see Key*

KEY 2: If necessary, use the following codes for the Trail Making Test only:
995 = Physical problem
996 = Cognitive/behavior problem
997 = Other problem
998 = Verbal refusal

7.	**Trail Making Test**		
	7a. Part A–Total number of seconds to complete (if not finished by 150 seconds, enter 150):	__ __ __	(0–150) *see Key 2*
	1) Number of commission errors	__ __	(0–40; *88 = N/A*)
	2) Number of correct lines	__ __	(0–24; *88 = N/A*)
	7b. Part B–Total number of seconds to complete (if not finished by 300 seconds, enter 300):	__ __ __	(0–300) *see Key 2*
	1) Number of commission errors	__ __	(0–40; *88 = N/A*)
	2) Number of correct lines	__ __	(0–24; *88 = N/A*)

8.	**WAIS-R Digit Symbol**		
	8a. Total number of items correctly completed in 90 seconds:	__ __	(0–93) *see Key*
9.	**Logical Memory IIA – Delayed**		
	9a. Total number of story units recalled:	__ __	(0–25) *see Key*
	9b. Time elapsed since Logical Memory IA – Immediate:	__ __	(0–85 minutes) (*88 = N/A*) (*99 = Unknown*)
10.	**Boston Naming Test (30 Odd-numbered items)**		
	10a. Total score:	__ __	(0–30) *see Key*

Check only <u>one</u> box below:

11. Overall Appraisal

11a. Based on the UDS neuropsychological examination, the subject's cognitive status is deemed:

- ☐ 1 Better than normal for age
- ☐ 2 Normal for age
- ☐ 3 One or two test scores abnormal
- ☐ 4 Three or more scores are abnormal or lower than expected
- ☐ 0 Clinician unable to render opinion

Institute for Memory Impairments and Neurological Disorders **11.09.2010**
Neuropsychological Test Sheet

Enter Score or Data Status Code (DSC) for each of the following tests
(Please complete with Black Ink)

	Score		Range
Global Measures			
MMSE		1	(0-30)
Affective State			
Geriatric Depression Rating Scale		2	(0-15)
CERAD Version: 1. STD 2. ALT1 3. ALT2 Enter number->		88	(1-3)
Recent Memory			
CERAD Word List meta-cognitive estimate		3	(0-10)
CERAD Word List			
Trial 1 recall, total		4	(0-10)
Trial 1 # intrusions		5	(0-10)
Trial 2 recall, total		6	(0-10)
Trial 2 # intrusions		7	(0-10)
Trial 3 recall, total		8	(0-10)
Trial 3 # intrusions		9	(0-10)
5-min delayed recall, total		10	(0-10)
5-min delayed recall, # intrusions		11	(0-10)
5-min recognition # Yes		12	(0-10)
5-min recognition # No		13	(0-10)
30-min delayed recall, total		14	(0-10)
30-min delayed recall, # intrusions		15	(0-10)
30 min. recognition # Yes		16	(0-10)
30 min. recognition # No		17	(0-10)
WMS-III Logical Memory 1			
Story A raw score		18	(0-25)
Story A thematic score		19	(0-7)
Story B 1st raw score		20	(0-25)
Story B 1st thematic score		21	(0-8)
Story B 2nd raw score		22	(0-25)
Story B 2nd thematic score		23	(0-8)

Not Done (ND)
-2 = ND - Physical Impairment
-3 = ND - Cognitive Impairment
-4 = ND - Subject Fatigue
-9 = ND - Out of Time
-10 = ND - Alternate Test
-11 = ND - Tester Error
-12 = ND - Lang./Cultural
Not Complete (NC)
-6 = NC - Too Slow
-7 = NC - Refused
-8 = NC - Cognitive Impairment

Data Center Use Only

Data Entry

1st Entry Date: _____ by: _____

2nd Entry Date: _____ by: _____

Checks Completed Date: _____ by: _____

Patient Name:_____ Tester Name:_____

Checked By:_____

Exam Date:_____ Date Submitted:_____

WMS-III Logical Memory 2				
Story A raw score			24	(0-25)
Story A thematic score			25	(0-8)
Story B raw score			26	(0-25)
Story B thematic score			27	(0-8)
WMS-III Faces				
WMS-III Faces 1 raw score			28	(0-48)
WMS-III Faces 2 raw score			29	(0-48)

Not Done (ND)
-2 = ND - Physical Impairment
-3 = ND - Cognitive Impairment
-4 = ND - Subject Fatigue
-9 = ND - Out of Time
-10 = ND - Alternate Test
-11 = ND - Tester Error
-12 = ND - Lang./Cultural
Not Complete (NC)
-6 = NC - Too Slow
-7 = NC - Refused
-8 = NC - Cognitive Impairment

Remote Memory

WAIS-R Information Version (1.STD 2.ALT1)		92	(1-2)
WAIS-R Information Raw Score		30	(0-29)

Attention & Concentration

WAIS-III Digit Span Forward		31	(0-16)
WAIS-III Digit Span Forward Length		80	(0-9)
WAIS-III Digit Span Backward		32	(0-14)
WAIS-III Digit Span Backward Length		81	(0-8)
WAIS-R Digit Span Forward		82	(0-12)
WAIS-R Digit Span Forward Length		83	(0-8)
WAIS-R Digit Span Backward		84	(0-12)
WAIS-R Digit Span BackwardLength		85	(0-7)
Symbol Digits Modality Test # Written		33	(0-110)
WAIS-R Digit Symbol		77	(0-93)

Language

30-item BNT, Total # Correct			34	(0-30)
30-item BNT # Semantic cues			35	
30-item BNT # Phonemic cues			36	(0-30)
30-item BNT # semantic paraphasias			38	(0-30)
30-item BNT # circumlocutions			37	(0-30)
30-item BNT # perseverations			89	(0-30)
30-item BNT # visual misidentification			90	(0-30)
CERAD Animal Naming # 0-15 sec			39	(0-30)
CERAD Animal Naming # 16-30 sec			40	(0-30)
CERAD Animal Naming # 31-45 sec			41	(0-30)
CERAD Animal Naming # 46-60 sec			42	(0-30)
CERAD Animal Naming # Intrusions			43	(0-30)
CERAD Animal Naming # Repetitions			44	(0-30)
CERAD Vegetable naming # 0-15 sec			71	(0-30)
CERAD Vegetable naming # 16-30 sec			72	(0-30)
CERAD Vegetable naming # 31-45 sec			73	(0-30)
CERAD Vegetable naming # 46-60 sec			74	(0-30)
CERAD Vegetable naming # Intrusions			75	(0-30)
CERAD Vegetable naming # Repetitions			76	(0-30)

Name:
PID: **Visit:**

Letter Fluency Version (1.FAS 2.BHR)			94	(1-2)
Letter Fluency F or B, # Correct			45	(0-60)
Letter Fluency F or B, # Repetitions			46	(0-30)
Letter Fluency F or B, # Intrusions			47	(0-30)
Letter Fluency A or H, # Correct			48	(0-60)
Letter Fluency A or H, # Repetitions			49	(0-30)
Letter Fluency A or H,# Intrusions			50	(0-30)
Letter Fluency S or R, # Correct			51	(0-60)
Letter Fluency S or R, # Repetitions			52	(0-30)
Letter Fluency S or R, # Intrusions			53	(0-30)

Not Done (ND)
-2 = ND - Physical Impairment
-3 = ND - Cognitive Impairment
-4 = ND - Subject Fatigue
-9 = ND - Out of Time
-10 = ND - Alternate Test
-11 = ND - Tester Error
-12 = ND - Lang./Cultural
Not Complete (NC)
-6 = NC - Too Slow
-7 = NC - Refused
-8 = NC - Cognitive Impairment

Visual-Spatial Abilities

CERAD circle		55	(0-2)
CERAD diamond		56	(0-3)
CERAD rectangles		57	(0-2)
CERAD cube		58	(0-4)
Read time		59	(0-3)
Set time		60	(0-3)
WAIS-III Block Design Raw Score		61	(0-68)
WAIS-III Block Design # completed		91	(0-14)

Executive Functioning

Trail Making Test, Part A seconds to complete			62	(10-150)
Trail Making Test, Part A # commission errors			63	(0-40)
Trail Making Test, Part A # correct lines			86	(0-24)
Trail Making Test, Part B seconds to complete			64	(10-300)
Trail Making Test, Part B # commission errors			65	(0-40)
Trail Making Test, Part B # correct lines			87	(0-24)
Trail Making Test, Part C seconds to complete			78	(5-60)
Trail Making Test, Part C # commission errors			79	(0-15)
Social Judgement			66	(0-6)
Insight: Memory			67	(0-2)
Insight: Non-Memory			93	(0-2)
WAIS-III Similarities Raw Score			68	(0-33)

Psychomotor Speed

Kendrick Digit Copy: Seconds to complete		69	(10-120)
Kendrick Digit Copy # completed in 2 minutes		70	(0-100)

Name:
PID: **Visit:**

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B9: Clinician Judgment of Symptoms

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B9. Check only one box per question.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

MEMORY COMPLAINT/AGE OF ONSET:	Yes	No
Relative to previously attained abilities:		
1. Does the subject report a decline in memory?	☐ 1	☐ 0
2. Does the informant report a decline in subject's memory?	☐ 1	☐ 0
3a. Does the clinician believe there has been a current meaningful decline in the subject's memory, non-memory cognitive abilities, behavior, or ability to manage his/her affairs, or have there been motor/movement changes?	☐ 1	☐ 0 (*If no, end form here*)
3b. At what age did the cognitive decline begin (based upon the clinician's assessment)?	__ __ __ (*999 = Unknown*) (*888 = N/A*)	

COGNITIVE SYMPTOMS:	Yes	No	Unknown
4. Indicate whether the subject currently is impaired meaningfully, relative to previously attained abilities, in the following cognitive domains or has fluctuating cognition:			
a. **Memory** (For example, does s/he forget conversations and/or dates; repeat questions and/or statements; misplace more than usual; forget names of people s/he knows well?)	☐ 1	☐ 0	☐ 9
b. **Judgment and problem-solving** (For example, does s/he have trouble handling money (tips); paying bills; shopping; preparing meals; handling appliances; handling medications; driving?)	☐ 1	☐ 0	☐ 9
c. **Language** (For example, does s/he have hesitant speech; have trouble finding words; use inappropriate words without self-correction?)	☐ 1	☐ 0	☐ 9
d. **Visuospatial function** (Difficulty interpreting visual stimuli and finding his/her way around.)	☐ 1	☐ 0	☐ 9
e. **Attention/concentration** (For example, does the subject have a short attention span or ability to concentrate? Is s/he easily distracted?)	☐ 1	☐ 0	☐ 9
f. **Fluctuating cognition** (Does s/he have pronounced variation in attention and alertness, noticeably over hours or days? For example, long periods of staring into space or lapses, or times when his/her ideas have a disorganized flow.)	☐ 1	☐ 0	☐ 9
g. **Other** (*If yes, then specify*): _____	☐ 1	☐ 0	☐ 9

(continued on next page)

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B9. Check only one box per question. ADC Visit #:__ __ __

5. Indicate the predominant symptom which was first recognized as a decline in the subject's cognition:	☐ 1 Memory ☐ 2 Judgment and problem solving ☐ 3 Language ☐ 4 Visuospatial function ☐ 5 Attention/concentration	☐ 6 Other (*specify*): _____ ☐ 7 Fluctuating cognition ☐ 88 N/A ☐ 99 Unknown
6. Mode of onset of cognitive symptoms:	☐ 1 Gradual (> *6 months*) ☐ 2 Subacute (≤ *6 months*) ☐ 3 Abrupt (*within days*)	☐ 4 Other (*specify*): _____ ☐ 88 N/A ☐ 99 Unknown

BEHAVIOR SYMPTOMS:	**Yes**	**No**	**Unknown**
7. Indicate whether the subject currently manifests the following behavioral symptoms:			
a. **Apathy/withdrawal** (Has the subject lost interest in or displayed a reduced ability to initiate usual activities and social interaction, such as conversing with family and/or friends?)	☐ 1	☐ 0	☐ 9
b. **Depression** (Has the subject seemed depressed for more than two weeks at a time; e.g., loss of interest or pleasure in nearly all activities; sadness, hopelessness, loss of appetite, fatigue?)	☐ 1	☐ 0	☐ 9
c. **Psychosis**			
1) Visual hallucinations	☐ 1	☐ 0	☐ 9
a) If yes, are the hallucinations well-formed and detailed?	☐ 1	☐ 0	☐ 9
2) Auditory hallucinations	☐ 1	☐ 0	☐ 9
3) Abnormal/false/delusional beliefs	☐ 1	☐ 0	☐ 9
d. **Disinhibition** (Does the subject use inappropriate coarse language or exhibit inappropriate speech or behaviors in public or in the home? Does s/he talk personally to strangers or have disregard for personal hygiene?)	☐ 1	☐ 0	☐ 9
e. **Irritability** (Does the subject overreact, such as shouting at family members or others?)	☐ 1	☐ 0	☐ 9
f. **Agitation** (Does the subject have trouble sitting still; does s/he shout, hit, and/or kick?)	☐ 1	☐ 0	☐ 9
g. **Personality change** (Does the subject exhibit bizarre behavior or behavior uncharacteristic of the subject, such as unusual collecting, suspiciousness [without delusions], unusual dress, or dietary changes? Does the subject fail to take other's feelings into account?)	☐ 1	☐ 0	☐ 9
h. **REM sleep behavior disorder** (Does the subject appear to act out his/her dreams while sleeping (e.g., punch or flail their arms, shout or scream?)	☐ 1	☐ 0	☐ 9
i. **Other** (*If yes, then specify*): _____	☐ 1	☐ 0	☐ 9

(continued on next page)

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form B9. Check only one box per question. ADC Visit #:__ __ __

8. Indicate the predominant symptom which was first recognized as a decline in the subject's behavioral symptoms:
   - ☐ 1 Apathy/withdrawal
   - ☐ 2 Depression
   - ☐ 3 Psychosis
   - ☐ 4 Disinhibition
   - ☐ 5 Irritability
   - ☐ 6 Agitation
   - ☐ 7 Personality change
   - ☐ 8 Other (*specify*): _____
   - ☐ 9 REM sleep behavior disorder
   - ☐ 88 N/A
   - ☐ 99 Unknown

9. Mode of onset of behavioral symptoms:
   - ☐ 1 Gradual (*> 6 months*)
   - ☐ 2 Subacute (*≤ 6 months*)
   - ☐ 3 Abrupt (*within days*)
   - ☐ 4 Other (*specify*): _____
   - ☐ 88 N/A
   - ☐ 99 Unknown

MOTOR SYMPTOMS:

	Yes	No	Unknown
10. Indicate whether the subject currently has the following motor symptoms:			
a. **Gait disorder** (Has the subject's walking changed, not specifically due to arthritis or an injury? Is s/he unsteady, or does s/he shuffle when walking, have little or no arm-swing, or drag a foot?)	☐ 1	☐ 0	☐ 9
b. **Falls** (Does the subject fall more than usual?)	☐ 1	☐ 0	☐ 9
c. **Tremor** (Has the subject had rhythmic shaking, especially in the hands, arms, legs, head, mouth, or tongue?)	☐ 1	☐ 0	☐ 9
d. **Slowness** (Has the subject noticeably slowed down in walking or moving or handwriting, other than due to an injury or illness? Has his/her facial expression changed, or become more "wooden" or masked and unexpressive?)	☐ 1	☐ 0	☐ 9

11. Indicate the predominant symptom which was first recognized as a decline in the subject's motor symptoms:
   - ☐ 1 Gait disorder
   - ☐ 2 Falls
   - ☐ 3 Tremor
   - ☐ 4 Slowness
   - ☐ 88 N/A
   - ☐ 99 Unknown

12. Mode of onset of motor symptoms:
   - ☐ 1 Gradual (*> 6 months*)
   - ☐ 2 Subacute (*≤ 6 months*)
   - ☐ 3 Abrupt (*within days*)
   - ☐ 4 Other (*specify*): _____
   - ☐ 88 N/A
   - ☐ 99 Unknown

a. If there were changes in motor function, were these suggestive of parkinsonism?
   - ☐ 1 Yes
   - ☐ 0 No
   - ☐ 88 N/A

OVERALL SUMMARY OF SYMPTOMS ONSET:

13. Course of overall cognitive/behavioral/motor syndrome:
   - ☐ 1 Gradually progressive
   - ☐ 2 Stepwise
   - ☐ 3 Static
   - ☐ 4 Fluctuating
   - ☐ 5 Improved
   - ☐ 9 Unknown

14. Indicate the predominant domain which was first recognized as changed in the subject:
   - ☐ 1 Cognition
   - ☐ 2 Behavior
   - ☐ 3 Motor function
   - ☐ 9 Unknown

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B4: Global Staging – Clinical Dementia Rating (CDR): Standard and Supplemental

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _ ADC Visit #:_ _ _ _

NOTE: This form is to be completed by the clinician or other trained health professional, based on informant report and neurological exam of the subject. In the extremely rare instances when no informant is available, the clinician or other trained health professional must complete this form utilizing all other available information and his/her best clinical judgment. Score only as decline from previous level due to cognitive loss, not impairment due to other factors. For further information, see UDS Coding Guidebook for Initial Visit Packet, Form B4.

Examiner's initials:_ _ _

SECTION 1: STANDARD CDR[1]

	IMPAIRMENT				
Please enter scores below	**None 0**	**Questionable 0.5**	**Mild 1**	**Moderate 2**	**Severe 3**
1. MEMORY _ _ . _ _	No memory loss, or slight inconsistent forgetfulness.	Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness.	Moderate memory loss, more marked for recent events; defect interferes with everyday activities.	Severe memory loss; only highly learned material retained; new material rapidly lost.	Severe memory loss; only fragments remain.
2. ORIENTATION _ _ . _ _	Fully oriented.	Fully oriented except for slight difficulty with time relationships.	Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere.	Severe difficulty with time relationships; usually disoriented to time, often to place.	Oriented to person only.
3. JUDGMENT & PROBLEM SOLVING _ _ . _ _	Solves everyday problems, handles business & financial affairs well; judgment good in relation to past performance.	Slight impairment in solving problems, similarities, and differences.	Moderate difficulty in handling problems, similarities, and differences; social judgment usually maintained.	Severely impaired in handling problems, similarities, and differences; social judgment usually impaired.	Unable to make judgments or solve problems.
4. COMMUNITY AFFAIRS _ _ . _ _	Independent function at usual level in job, shopping, volunteer and social groups.	Slight impairment in these activities.	Unable to function independently at these activities, although may still be engaged in some; appears normal to casual inspection.	No pretense of independent function outside the home; appears well enough to be taken to functions outside the family home.	No pretense of independent function outside the home; appears too ill to be taken to functions outside the family home.
5. HOME & HOBBIES _ _ . _ _	Life at home, hobbies, and intellectual interests well maintained.	Life at home, hobbies, and intellectual interests slightly impaired.	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned.	Only simple chores preserved; very restricted interests, poorly maintained.	No significant function in the home.
6. PERSONAL CARE . **0**	Fully capable of self-care (= 0).		Needs prompting.	Requires assistance in dressing, hygiene, keeping of personal effects.	Requires much help with personal care; frequent incontinence.
7. _ _ _ . _ _	**STANDARD CDR SUM OF BOXES**				
8. _ _ . _ _	**STANDARD GLOBAL CDR**				

PID:
Visit:

[1] Morris JC. The Clinical Dementia Rating (CDR): Current version and scoring rules. *Neurology* 43(11):2412-4, 1993.

Center: 31 ADC Subject ID: __ __ __ __ __ __ __ __ __ __ Form Date: __ __/__ __/__ __ __ __ ADC Visit #:__ __ __

NOTE: This form is to be completed by the clinician or other trained health professional, based on informant report and neurological exam of the subject. In the extremely rare instances when no informant is available, the clinician or other trained health professional must complete this form utilizing all other available information and his/her best clinical judgment. Score only as decline from previous level due to cognitive loss, not impairment due to other factors. For further information, see UDS Coding Guidebook for Initial Visit Packet, Form B4.

SECTION 2: SUPPLEMENTAL CDR

	IMPAIRMENT				
Please enter scores below	**None 0**	**Questionable 0.5**	**Mild 1**	**Moderate 2**	**Severe 3**
9. BEHAVIOR, COMPORTMENT AND PERSONALITY[2] __·__	Socially appropriate behavior.	Questionable changes in comportment, empathy, appropriateness of actions.	Mild but definite changes in behavior.	Moderate behavioral changes, affecting interpersonal relationships and interactions in a significant manner.	Severe behavioral changes, making interpersonal interactions all unidirectional.
10. LANGUAGE[3] __·__	No language difficulty or occasional mild tip-of-the-tongue.	Consistent mild word finding difficulties; simplification of word choice; circumlocution; decreased phrase length; and/or mild comprehension difficulties.	Moderate word finding difficulty in speech; cannot name objects in environment; reduced phrase length and/or agrammatical speech; and/or reduced comprehension in conversation and reading.	Moderate to severe impairments in either speech or comprehension; has difficulty communicating thoughts; writing may be slightly more effective.	Severe comprehension deficits; no intelligible speech.

PID:
Visit:

[2] Excerpted from the Frontotemporal Dementia Multicenter Instrument & MR Study (Mayo Clinic, UCSF, UCLA, UW).

[3] Excerpted from the PPA-CRD: A modification of the CDR for assessing dementia severity in patients with Primary Progressive Aphasia (Johnson N, Weintraub S, Mesulam MM). 2002.

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NACC Uniform Data Set (UDS) – Initial Visit Packet

Form D1: Clinician Diagnosis – Cognitive Status and Dementia

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by the clinician. For diagnostic criteria, see UDS Coding Guidebook for Initial Visit Packet, Form D1. Check only one box per response category.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

1. Responses are based on: ☐ 1 Diagnosis from single clinician ☐ 2 Consensus diagnosis

2. Does the subject have normal cognition (no MCI, dementia, or other neurological condition resulting in cognitive impairment)?	☐ 1 Yes *(If yes, skip to #14)*	☐ 0 No *(If no, continue to #3)*
3. Does the subject meet criteria for dementia (in accordance with standard criteria for dementia of the Alzheimer's type or for other non-Alzheimer's dementing disorders)?	☐ 1 Yes *(If yes, skip to #5)*	☐ 0 No *(If no, continue to #4)*

4. If the subject does not have normal cognition and is not clinically demented, indicate the type of cognitive impairment (*choose only one impairment from items 4a thru 4e as being "present"; mark all others "absent"*) **and then designate the suspected underlying cause(s) of the impairment by completing items 5–30:**

	Present	Absent	Domains	Yes	No
4a. Amnestic MCI – memory impairment only	☐ 1	☐ 0			
4b. Amnestic MCI – memory impairment plus one or more other domains (*if present, check one or more domain boxes "yes" and check all other domain boxes "no"*)	☐ 1	☐ 0	1) Language	☐ 1	☐ 0
			2) Attention	☐ 1	☐ 0
			3) Executive function	☐ 1	☐ 0
			4) Visuospatial	☐ 1	☐ 0
4c. Non-amnestic MCI – single domain (*if present, check only one domain box "yes"; check all other domain boxes "no"*)	☐ 1	☐ 0	1) Language	☐ 1	☐ 0
			2) Attention	☐ 1	☐ 0
			3) Executive function	☐ 1	☐ 0
			4) Visuospatial	☐ 1	☐ 0
4d. Non-amnestic MCI – multiple domains (*if present, check two or more domain boxes "yes" and check all other domain boxes "no"*)	☐ 1	☐ 0	1) Language	☐ 1	☐ 0
			2) Attention	☐ 1	☐ 0
			3) Executive function	☐ 1	☐ 0
			4) Visuospatial	☐ 1	☐ 0
4e. Impaired, not MCI	☐ 1	☐ 0			

Center: 31 ADC Subject ID: _ _ _ _ _ _ _ _ _ _ Form Date: _ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician. For diagnostic criteria, see UDS Coding Guidebook for Initial Visit Packet, Form D1. Check only one box per response category.

ADC Visit #: _ _ _

Please indicate if the following conditions are present or absent. If present, also indicate if the condition is primary or contributing to the observed cognitive impairment (reported in items 3 or 4), based on the clinician's best judgment. Mark only one condition as primary.

		Present	Absent		If Present: Primary	If Present: Contributing
5.	Probable AD (NINCDS/ADRDA) *(if present, skip to item #7)*	☐ 1	☐ 0	5a.	☐ 1	☐ 2
6.	Possible AD (NINCDS/ADRDA) *(if #5 is present, leave this blank)*	☐ 1	☐ 0	6a.	☐ 1	☐ 2
7.	Dementia with Lewy bodies	☐ 1	☐ 0	7a.	☐ 1	☐ 2
8.	Vascular dementia (NINDS/AIREN Probable) *(if present, skip to item #10)*	☐ 1	☐ 0	8a.	☐ 1	☐ 2
9.	Vascular dementia (NINDS/AIREN Possible) *(if #8 is present, leave this blank)*	☐ 1	☐ 0	9a.	☐ 1	☐ 2
10.	Alcohol-related dementia	☐ 1	☐ 0	10a.	☐ 1	☐ 2
11.	Dementia of undetermined etiology	☐ 1	☐ 0	11a.	☐ 1	☐ 2
12.	Frontotemporal dementia (behavioral/executive dementia)	☐ 1	☐ 0	12a.	☐ 1	☐ 2
13.	Primary progressive aphasia (aphasic dementia)	☐ 1	☐ 0	13a.	☐ 1	☐ 2
	(If PPA is present, specify type by checking one box below "present" and all others "absent"):					
	1) Progressive nonfluent aphasia	☐ 1	☐ 0			
	2) Semantic dementia – anomia plus word comprehension	☐ 1	☐ 0			
	3) Semantic dementia – agnostic variant	☐ 1	☐ 0			
	4) Other (e.g., logopenic, anomic, transcortical, word deafness, syntactic comprehension, motor speech disorder)	☐ 1	☐ 0			

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by the clinician. For diagnostic criteria, see UDS Coding Guidebook for Initial Visit Packet, Form D1. Check only one box per response category.

ADC Visit #:_ _ _

For subjects with normal cognition, indicate whether the following conditions are present or absent. If the subject is cognitively impaired, indicate also whether the condition is primary, contributing or non-contributing to the observed cognitive impairment, based on your best judgment. Mark only one condition as primary.

		Present	Absent		If Present: Primary	Contributing	Non-contrib.
14.	Progressive supranuclear palsy	☐ 1	☐ 0	14a.	☐ 1	☐ 2	☐ 3
15.	Corticobasal degeneration	☐ 1	☐ 0	15a.	☐ 1	☐ 2	☐ 3
16.	Huntington's disease	☐ 1	☐ 0	16a.	☐ 1	☐ 2	☐ 3
17.	Prion disease	☐ 1	☐ 0	17a.	☐ 1	☐ 2	☐ 3
18.	Cognitive dysfunction from medications	☐ 1	☐ 0	18a.	☐ 1	☐ 2	☐ 3
19.	Cognitive dysfunction from medical illnesses	☐ 1	☐ 0	19a.	☐ 1	☐ 2	☐ 3
20.	Depression	☐ 1	☐ 0	20a.	☐ 1	☐ 2	☐ 3
21.	Other major psychiatric illness	☐ 1	☐ 0	21a.	☐ 1	☐ 2	☐ 3
22.	Down's syndrome	☐ 1	☐ 0	22a.	☐ 1	☐ 2	☐ 3
23.	Parkinson's disease	☐ 1	☐ 0	23a.	☐ 1	☐ 2	☐ 3
24.	Stroke	☐ 1	☐ 0	24a.	☐ 1	☐ 2	☐ 3
25.	Hydrocephalus	☐ 1	☐ 0	25a.	☐ 1	☐ 2	☐ 3
26.	Traumatic brain injury	☐ 1	☐ 0	26a.	☐ 1	☐ 2	☐ 3
27.	CNS neoplasm	☐ 1	☐ 0	27a.	☐ 1	☐ 2	☐ 3
28.	Other (*specify*): _____	☐ 1	☐ 0	28a.	☐ 1	☐ 2	☐ 3
29.	Other (*specify*): _____	☐ 1	☐ 0	29a.	☐ 1	☐ 2	☐ 3
30.	Other (*specify*): _____	☐ 1	☐ 0	30a.	☐ 1	☐ 2	☐ 3

Consensus Diagnosis (State)

Syndrome

1. o **Diagnosis Deferred**
   (Complete causal factors)
2. o **No Cognitive Impairment**
   (Finished)
3. o **Questionable Cognitive Impairment – Includes AAMI, and ARCD**
   (Finished)
4. o **Delirium – Impaired attention and disorganized thinking conforming to DMS-IV criteria**
   (Complete causal factors, diagnosis, and family history)
5. o **Dementia – Cognitive impairment which conforms to DSM-IV criteria modified to exclude etiology as a criterion**
   (Complete causal factors, diagnosis, and family history)

   If Dementia selected, then:
   Initial Symptom Onset Date: ____ / ____ / _____ Dementia DX Date: ____ / ____ / _____
6. o **Other cognitive impairment not meeting criteria for dementia**
   (Complete causal factors, family history, and the following items)

Complete if "Other cognitive impairment not meeting criteria for dementia" is selected

	No Impairment (<1 SD)	Mild (≥1 SD, <1.5 SD)	Moderate (≥1.5 SD, <2.0 SD)	Severe (≥ 2.0 SD)	Not Assessed
12a. **Memory**	1	2	3	4	8
12b. **Executive**	1	2	3	4	8
12c. **Language**	1	2	3	4	8
12d. **Visuospatial**	1	2	3	4	8

_____ _____
Neurologist Signature **Date**

_____ _____
Neuropsychologist Signature **Date**

Consensus Diagnosis (State)

Causal Factors

	Very Likely	Somewhat Likely	No	Causal Factor
13a	o	o	o	Alzheimer's disease
13b	o	o	o	Cerebrovascular disease
13c	o	o	o	Parkinson's disease
13d	o	o	o	Lewy Body disease
13e	o	o	o	Pick's disease or other frontal temporal syndrome
13f	o	o	o	NPH
13g	o	o	o	Progressive supranuclear palsy
13h	o	o	o	Depressive mood disorder
13i	o	o	o	Current alcohol use
13j	o	o	o	Past alcohol use
13k	o	o	o	Drug misuse or abuse
13l	o	o	o	Medication (prescribed: toxic effect or metabolic derangement)
13m	o	o	o	Metabolic disorder
13n	o	o	o	Toxin
13o	o	o	o	Head trauma
13p	o	o	o	CNS infections (including HIV)
13q	o	o	o	Non-CNS infections
13e	o	o	o	Space-occupying lesion
13s	o	o	o	Other (e.g., neurosurgery, hypoxia, anoxia)

Diagnosis

For patients *with a dementia*, indicate the primary diagnosis(es). Make every effort to identify a single diagnosis. Choose a diagnosis that is related to the causal factor with the highest likelihood. Choose mixed diagnoses if two or more causal factors are equally likely.

14a o Possible AD (NINCDS criteria)
14b o Probable AD (NINCDS criteria)
14c o Possible ischemic vascular dementia (ADDTC Criteria)
14d o Probable ischemic vascular dementia (ADDTC Criteria)
14e o Cerebrovascular disease not meeting ADDTC criteria for vascular dementia
14f o Parkinson's Disease
14g o Possible dementia with Lewy bodies (DLB consortium criteria)
14h o Probable dementia with Lewy bodies (DLB consortium criteria)
14i o Frontal temporal lobe degeneration (FTD consensus criteria)
14j o Normal pressure hydrocephalus
14k o Progressive supranuclear palsy
14l o Depressive mood disorder (DSM-IV criteria)
14m o Alcohol abuse or dependence (DSM-IV criteria)
14n o Drug abuse or dependence (DSM-IV criteria)
14o o Medication (Toxic effect or metabolic derangement)
14p o Metabolic disorder
14q o Toxin
14r o Head trauma
14s o CNS Infection
14t o Space-occupying lesion
14v o Diagnosis undetermined
14w o Other: _____

Consensus Diagnosis

_____ Completed By (Initials)
_____ Date

Name:
PID: Visit:

Consensus Diagnosis (State)

15. Family History of cognitive disorder or dementia

Is the patient's family history of a cognitive disorder or dementia consistent with:

1. o - Autosomal dominant inheritance
2. o - Autosomal recessive inheritance
3. o - Other inheritance pattern
4. o - No family history
5. o - Not determined

Autosomal dominant **disorder would be coded as "1" if one parent had the disease and some of the offspring (statistically about half) had the disease. It would be further supported by a multigenerational history of a similar disorder, if a multigenerational history is obtained.**

Autosomal recessive **would be coded as "2" if the parents are free of disease but one or more offspring develop the disease, there may or may not be a family history. This would further be supported if the parents are related. Other information about the disease like how it is usually inherited can play into the equation.**

Other inheritance pattern **would be coded as "3" if there is a pattern of inheritance but it does not fit with autosomal dominant or autosomal recessive disorder (e.g., maternal inheritance, or a family history of a similar disease but with insufficient information to determine inheritance).**

No family history of inheritance **would be coded as "4" if the family history is not suggestive of a pattern of inheritance.**

Code "5" for not determined.

NACC NP Data Form Version 9.1 17A

Choose one of the following categories that most accurately describes the family information available. If there is more than one relevant disorder in the family history, enter the most descriptive in the space provided and omit the other(s).

16A. Family history information relevant to neuropathologic diagnosis.
Choose one of the following categories that most accurately describes the family information available: (*mark one box)*

1. o - Family history of similar neurodegenerative disorder
2. o - Family history of other (dissimilar) neurodegenerative disorder
3. o - No family history of similar or dissimilar neurodegenerative disorder
4. o - Family history of both similar and dissimilar neurodegenerative disorder
9. o - Family history unknown/not available/missing

16B. If 16A is 2 or 4, specify disorder:

_____

Clinician Diagnosis (Supplement)

Autopsy Information (always complete)

If Patient were to come to autopsy at UCI, what brain hemisphere should the Neuropathologist examine?
(If Both are significant then conference with Neuropathologist to determine hemisphere for autopsy)

1)
1. o Left
2. o Right **Based on:** _____
3. o Either

Subject Onset / Diagnosis Dates

2) If not normal:
Onset Date (mo/year): ___/___ / _____

3) If diagnosed with dementia:
Dementia DX Date (mo/year): ___/___ / _____

UDS Neuropsychological Battery Overall Appraisal

Based on the UDS neuropsychological examination, the subject's cognitive status is deemed:

4)
1. o Better than normal for age
2. o Normal for age
3. o One or two test scores abnormal
4. o Three or more scores are abnormal or lower than expected
0. o Clinician unable to render opinion

(transfer to UDS form C1 Question 11)

Subject Cohort Transition due to current diagnosis

Based on this examination, the subject should be moved from:

5) o YES (end here) o NO 5) CADC ONLY

5a) o YES o NO (end here) ADRC Change Cohort?

5b)
1. o Control Cohort to Patient Cohort
2. o Patient Cohort to Home Visit Cohort
3. o Home Visit Cohort to Telephone / Mailer Only Cohort
4. o Patient Cohort to Control Cohort

Additional / Unusual Findings (use back of this page for additional space):

Clinician Diagnosis (Supplement)

Recommendations

1) Non-Pharmacological / Behavioral Recommendations		
	AAOC Care Consultant	
	Adult Day Care	Start Continue
	Alternative Living Arrangements	Consider
	Case Management	
	Depression	Start Continue
	Safe Return Program	Start Continue
	Exercise	Start Continue
	Institute for Brain Aging Educational Series	
	New Connections Club (NCC)	
	"Jumpstart" Program	
	AAOC Early Memory Loss Group	
	Psychiatrist	
	Psychologist / Counseling	
	Recommend Support Groups	Start Continue
	Stop alcohol	
	Stop smoking	
	Three-Week Caregiver Education Series	

2) Legal Recommendations	
	Advanced Health Care Directives
	Availability of weapons in household
	Driving concerns
	Driver Evaluation
	Elder Abuse - Caregiver
	Elder Abuse - Patient

(Check one or more for each)

Neurologist: Cable Thai

Neuropsychologist: Dick

Psychometrist:

K. Bui M. Carafa E. Garza
S. Park S. Randhawa E. Smith

Comments:

3) Medical / Pharmacological Recommendations				
	Cardiologist evaluation			
	Establish Primary Care Physician			
	Private Practice			
	Aspirin	Start Continue		
	B-12 management	Start Continue		
	Coumadin Management			
	Vitamin E	High (2000 IU/day) Low (400 IU/day)	Start Continue	
	Vitamin C (500 mg/day)	Start Continue		
	Aricept	Start Continue Increase	5 mg 10 mg	Stop
	Exelon	Start Continue Increase	1.5 mg/bid 3 mg/bid 4.5 mg/bid 6 mg/bid	Stop
	Razadyne / Reminyl	Start Continue Increase	4 mg/bid 8 mg/bid 12 mg/bid	Stop
	Namenda / Memantine	Start Continue Titrate to Max	5 mg 10 mg 15 mg 20 mg	Stop

4) Diagnostic Tests Recommendations	
	MRI/CT-Structural Imaging
	SPECT

5) Clinical Research Study Options	
	Alzheimer's Disease Neuroimaging Initiative-GO Study
	Eli Lilly LY2062430 Treatment Study for AD
	IGIV Treatment Study for AD (GAP Study)
	Nicotinamide Treatment Study for AD

6) Research Recommendations	
	ADRC Research Candidate
	In-Clinic Cohort to Home Cohort conversion

Recommendations

Inclusion / Exclusion Criteria

In order to be considered for participation in the ADRC the subject must meet certain inclusion criteria. The participant must meet one of the diagnosis, race and autopsy criteria.

Inclusion Criteria	
Diagnosis	
1.	Normal Cognition
2.	Previous ADRC Control
3.	MCI (all types)
4.	Atypical Dementia
5.	Very Early AD (MMSE ≥20)
Race and Language	
6.	Caucasian
7.	English or Spanish Speaking Hispanic/Latino
8.	English Speaking other ethnic background
9.	Minority that does not speak English
Autopsy Consent	
10.	Willing to consent to autopsy
11.	Not willing to consent to autopsy
12.	Undecided to consent to autopsy
Compliance	
13.	Lives locally or travels only short distance
14.	Expresses a strong interest & compliant with clinic procedures
Informant	
15.	Lives with the participant
16.	Relative or friend with frequent contact and lives locally
Other Research	
17.	Interested in participating in collaborative research
18.	Currently participates in additional research at UCI
19.	Interested in clinical trials at UCI
Reason for Exclusion Clinician reason for indicating subject is **NOT Eligible** for enrollment in the ADRC	
20.	Subject outside of research interest
21.	Impaired scores on DSRS, FAQ, or Neuropsych battery in a control
22.	Moderate - Severe AD (MMSE <19)
23.	Informant is a neighbor
24.	Informant has very little contact or only long-distance contact
25.	Non-English speaking minority without a bi-lingual liaison to assist with the assessment
26.	Caucasian not willing to enroll in tissue donation
27.	Patient lives out of state/requires long-distance travel
28.	Non-compliant (frequent cancellations, not willing to sign consents) or high liability

University of California, Irvine
Institute for Memory Impairments and Neurological Disorders
DRIVER SAFETY REPORTING FORM

Date of neurological exam: _____

Date of family conference: _____

£ **Reported (DMV Morbidity Report completed)**

£ **Not reported**

Justification / comments: _____
_____
_____
_____
_____
_____
_____

_____ _____

Neurologist's Signature **Date**

UNIVERSITY OF CALIFORNIA, IRVINE

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

Alzheimer's Disease Diagnostic
and Research Center

1100 Medical Plaza
Irvine, CA 92697-4285
Phone: (949) 824-ADTC (2382)
Fax: (949) 824-3049 FAX
http://www.mind.uci.edu

DATE:_____

RE:_____

To Whom It May Concern,

A *family conference* has been scheduled for Date:_____ Time:_____ at the Gottschalk Medical Plaza located in Irvine. Please check in at thee Alzheimer's Assessment Center. This consultation is available to you and your family and allows you a chance to meet "one-on-one" with the doctors to discuss the diagnosis and recommendations reached through the recent assessment that was completed on: _____ and _____. The patient must be present at this appointment. If he/she is not able to attend, you will receive the results by mail. If this is not a convenient time for you, please let me know.

Please call me at (949) 824-2382 if you have any questions. It is our goal that you and your family will have a better understanding of the evaluation.

Thank you,

Switaya (Ken) Krisnasmit
Patient Care Coordinator
UCI Alzheimer's Disease Research and Treatment Center

Authorization to Release Patient Information

I request that the letter describing the results of my evaluation be sent to the individuals listed below. In addition to the diagnosis and treatment plan, I understand that this letter will contain information concerning my physical and neurological examinations, the neuropsychological assessment, and laboratory tests. This letter may also contain information pertaining to mental health issues, current medications, drug and alcohol treatment, as well as my personal and family medical history.

PATIENT NAME: _____ **CID #:**_____

Name: _____ Relationship: _____

Street: _____

City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Street: _____

City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Street: _____

City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Street: _____

City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Street: _____

City: _____ State: _____ Zip: _____

_____ _____

Patient Signature Date

_____ _____

Signature of Legally Authorized Representative Date

_____ _____

Date S.L. Mailed Date F.C. Mailed

Institute for Memory Impairments and Neurological Disorders
Authorization for Use and Disclosure of Information on Services Rendered

EXPLANATION

This authorization for use or disclosure of information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 *et seq*.

AUTHORIZATION

I, _____: hereby authorize the following
Name of Patient/Legally Authorized Representative

_____
Name of Social Worker, Case Manager, or Health Care Provider

Alzheimer's Association of Orange County
Title of the Organization

2540 North Santiago Boulevard, Orange, CA. 92867
Address, City, State, Zip Code

(714) 283-1111 (714) 283-1240
Phone Number Fax Number

to furnish the Institute for Memory Impairments and Neurological Disorders at the University of California, Irvine with information about services rendered to_____
Name of Patient

This authorization is limited to information about after-care services rendered to the above-named patient following the diagnostic conference at the Institute.

USES

The requestor may use the authorized information for the following purposes: (1) to coordinate the above-named patient's care, (2) address any difficulties encountered in implementing the recommended treatment plan, and (3) evaluate the success of the treatment recommendations.

DURATION

This authorization shall become effective immediately and shall remain in effect until: _____
Date

RESTRICTIONS

I understand that the requester may not further use or disclose this information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: ¨ Yes ¨ No Initial: _____

SIGNATURE

Signature: _____ _____
(Please circle: Patient/Legal Representative) (Date)

If signed by other than the participant, indicate relationship: _____

Witness: _____

phone: (206) 543-8637; fax: (206) 616-5927
e-mail: naccmail@u.washington.edu
website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form Z1: Form Checklist

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by clinic staff. ADC Visit #:__ __ __

Examiner's initials: __ __ __

NACC expects and intends that all UDS forms will be attempted on all subjects, but we realize this may be impossible when the patient is terminally ill, or when there is no informant, or for other reasons. NACC requires that Forms Z1, A1, A5, B4, B9, C1, D1, and E1 be submitted for a subject to be included in the UDS database, even though these forms may include some missing data.

For forms not designated as required, if it is not feasible to collect all or almost all of the data elements for a subject and the ADC therefore decides not to attempt collection of those data, an explanation must be provided. Please indicate this decision below by including the appropriate explanatory code and any additional comments.

KEY: If the specified form was not completed, please enter one of the following codes:

95 = Physical problem
96 = Cognitive/behavior problem
97 = Other problem
98 = Verbal refusal

Form	Description	Submitted: Yes	Submitted: No	If not submitted, specify reason (see Key)	Comments (provide if needed)
A1	Subject Demographics	**REQUIRED**		n/a	n/a
A2	Informant Demographics	☐ 1	☐ 0	__ __	
A3	Subject Family History	☐ 1	☐ 0	__ __	
A4	Subject Medications	☐ 1	☐ 0	__ __	
A5	Subject Health History	**REQUIRED**		n/a	n/a
B1	Evaluation Form – Physical	☐ 1	☐ 0	__ __	
B2	Evaluation Form – HIS and CVD	☐ 1	☐ 0	__ __	
B3	Evaluation Form – UPDRS	☐ 1	☐ 0	__ __	
B4	Global Staging – CDR: Standard and Supplemental	**REQUIRED**		n/a	n/a
B5 or B5S	Behavioral Assessment – NPI-Q	☐ 1	☐ 0	__ __	
B6 or B6S	Behavioral Assessment – GDS	☐ 1	☐ 0	__ __	
B7 or B7S	Functional Assessment – FAQ	☐ 1	☐ 0	__ __	

Center: 31 ADC Subject ID:_ _ _ _ _ _ _ _ _ _ Form Date:_ _/_ _/_ _ _ _

NOTE: This form is to be completed by clinic staff. ADC Visit #:_ _ _

KEY: If the specified form was not completed, please enter one of the following codes:

95 = Physical problem
96 = Cognitive/behavior problem
97 = Other problem
98 = Verbal refusal

Form	Description	Submitted: Yes	Submitted: No	If not submitted, specify reason (see Key)	Comments (provide if needed)
B8	Evaluation – Physical/Neurological Exam Findings	☐ 1	☐ 0	_ _	
B9	Clinician Judgment of Symptoms	**REQUIRED**		n/a	n/a
C1 or C1S	MMSE and Neuropsychological Battery	**REQUIRED**		n/a	n/a
D1	Clinician Diagnosis Cognitive Status and Dementia	**REQUIRED**		n/a	n/a
E1	Imaging/Labs	**REQUIRED**		n/a	n/a

phone: (206) 543-8637; fax: (206) 616-5927
e-mail: naccmail@u.washington.edu
website: www.alz.washington.edu

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form E1: Imaging/Labs

Center: 31 ADC Subject ID:__ __ __ __ __ __ __ __ __ __ Form Date:__ __/__ __/__ __ __ __

NOTE: This form is to be completed by ADC or clinic staff. For additional clarification and examples, see UDS Coding Guidebook for Initial Visit Packet, Form E1.Check only one box per response category.

ADC Visit #:__ __ __

Examiner's initials:__ __ __

Neuroimaging available at your ADC:		Film Yes	Film No		Digital image Yes	Digital image No
1. Computed tomography	1a.	☐ 1	☐ 0	1b.	☐ 1	☐ 0
2. Magnetic resonance imaging – Clinical study	2a.	☐ 1	☐ 0	2b.	☐ 1	☐ 0
3. Magnetic resonance imaging – Research study/structural	3a.	☐ 1	☐ 0	3b.	☐ 1	☐ 0
4. Magnetic resonance imaging – Research study/functional	4a.	☐ 1	☐ 0	4b.	☐ 1	☐ 0
5. Magnetic resonance spectroscopy	5a.	☐ 1	☐ 0	5b.	☐ 1	☐ 0
6. SPECT	6a.	☐ 1	☐ 0	6b.	☐ 1	☐ 0
7. PET	7a.	☐ 1	☐ 0	7b.	☐ 1	☐ 0

Specimens available at your ADC:	Yes	No
8. DNA	☐ 1	☐ 0
9. Cerebrospinal fluid – ante-mortem	☐ 1	☐ 0
10. Serum/plasma	☐ 1	☐ 0

Genotyping results:	Yes	No
11. APOE genotype collected	☐ 1	☐ 0