Thank you for your interest and commitment to our program. You are one of approximately 350 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 2½ to 3 hours for this visit)

NEUROLOGICAL ASSESSMENT DATE: ________________ TIME: ______ AM ______ PM
(Please allow a minimum of 1½ to 2 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 Supervisor
UCI Institute for Memory Impairments and Neurological Disorders
## Checklist

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

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

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

### Caregiver/Informant
- Fill out the enclosed paperwork and bring it with you to the office visit.
- 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. These may include the following:
  - Laboratory tests/bloodwork
  - Films (e.g., MRI, CT, PET scans)
  - Doctor’s or medical reports.
- Bring a sweater or jacket as temperatures in the waiting and examination rooms vary.
- 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.).
Participants in our research program receive the following multi-step evaluation:

- **Clinical Evaluation:** The clinical evaluation typically involves two separate visits, one lasting 2 ½ to 3 hours (neuropsychological testing) and another lasting 1½ to 2 hours (neurological/physical exam). A spouse, close friend, or relative who can provide information about the research participant’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 participant’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 or CT) and blood tests may be recommended and our staff can help schedule these appointments.

- **Comprehensive Report:** After the results from the annual clinical evaluation have been analyzed and there are no significant changes, a comprehensive letter describing the findings from the clinical evaluation and treatment recommendations is mailed to the research participant, his/her primary care physician, and other designated parties.

- **Optional Family Conference:** Based upon the results from the annual clinical evaluation, UCI MIND clinicians may recommend the research participant and his/her family 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.

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
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,

Aimee L. Pierce, M.D.
Assistant Clinical Professor, Department of Neurology
Institute for Memory Impairments and Neurological Disorders
Thank you for participating in our Brain Autopsy Program. The decision to donate your brain to research is an important and personal choice. We appreciate the valuable contribution both you and your family have chosen to make. The autopsy allows us to confirm the clinical diagnosis for the family and advance our knowledge of the kind of changes that take place in the brain during aging and dementia.

It is essential that you and your family know the steps to take upon death. The UCI MIND Brain Bank/Tissue Repository has a 24-hour paging system for tissue donation, which is active 7 days a week, even during holidays. It is vital to the autopsy procedure that we be contacted immediately at the time of death. This critical period, called the “post-mortem interval” greatly impacts the quality of the donated tissue and allows for the greatest use of the tissue by other dementia specialty centers throughout the country. The participant will be provided with brain donation cards to keep in case of emergency.

If you would like additional donor cards, please contact our clinical offices at (949) 824-2382. Additional cards may also be provided to close relatives to inform them of our procedures and your wishes to donate your brain to the Institute.

**BRAIN DONATION PROCEDURES:**

1) At time of death, the next-of-kin or attending physician should immediately contact our Tissue Repository staff using our 24-hour emergency pager. If you leave a message and do not receive a return call in approximately 20 minutes, please call the alternate pager number.
   
   24-hour Emergency Pager #: (714) 506-4004
   Alternate Pager #: (714) 506-4005

2) The Tissue Repository staff will arrange for the body to be transported to the UCI Medical Center in Orange. This is where the brain removal occurs and usually this procedure does not take longer than 6-12 hours.

3) Once the brain harvesting procedure is completed, the body will be transported directly to the family’s preselected funeral home or mortuary.

4) The extracted brain will then be transported to our Tissue Repository, located at UC Irvine, for our neuropathologist to examine. Due to the specialized tissue staining required, a detailed neuropathological analysis takes 3-5 months to complete. The family will receive a written report of the findings of our neuropathology studies as soon as the information is available.

If you have any additional (non-emergency) questions you may contact our Tissue Repository staff at (949) 824-5032.
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

UC Irvine Healthcare Unit and/or Clinic requesting Health Information

UCI Institute for Memory Impairments and Neurological Disorders, P: (949) 824-2382 F: (949) 824-3049

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  ☒ Radiology Reports  ☒ Consultations
☒ Progress Notes  ☒ Outpatient Clinic Records
☐ Vaccinations/Immunizations

☐ 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)).
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

(Signature of Patient or Patient’s Legal Representative) ________________________________

Date: ______________________________

(Printed Name)

Time: ______________ AM/PM

Witness or Translator

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

Page 2 of 2 83500 (Rev. 9/26/08)
Date sent: ____________________

Thank you for your continued participation at the UCI Institute for Memory Impairments and Neurological Disorders. Enclosed you will find a questionnaire which needs to be completed by the caregiver/informant. Please return the completed questionnaire in the postage-paid envelope provided. 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

Ruobing (Robin) Li  
Patient Care Coordinator
University of California, Irvine
Informant Study Information Sheet

Alzheimer’s Disease Research Center (ADRC) at the University of California, Irvine

Lead Researcher*
Malcolm Dick, Ph.D.
Institute for Memory Impairments and Neurological Disorders
(949) 824-2382

* additional personnel listed in Protocol Narrative

- You are being asked to participate in this research study because you are the designated informant for a study participant. Scientists at the UCI Institute for Memory Impairments and Neurological Disorders are conducting a research study to learn more about how an individual’s memory and thinking abilities change during normal aging and in various neurological disorders, such as Alzheimer’s disease (AD). This research study is being conducted as part of the UCI-Alzheimer’s Disease Research Center (ADRC) that is supported by the National Institute on Aging (NIA).

- As the designated informant, you will be asked to complete a number of short questionnaires that provide us with information about the participant. These questionnaires will take about 30 minutes to complete and can be done either through the mail or over the telephone. The questionnaires provide us with information about the participant’s everyday living skills, cognitive abilities, personality, and affective state. In addition to providing information about the participant, we will be gathering information about you. This information will include your month and year of birth, gender, ethnicity, years of education, relationship to the study participant (e.g., spouse, adult child, friend, neighbor), and the frequency that you have contact with the participant.

- There are no significant risks involved in being an informant for the study participant. You will simply be answering questions about the participant’s abilities to the best of your knowledge. If you do not know the answer to a particular question, you can leave it blank.

- There will be no direct benefits to you. This study is being carried out as basic research to increase our understanding of AD and how mental abilities change with age. As AD and the related disorders become better understood, it may be possible to manage and treat individuals with these diseases more effectively.

- Participation in this study is voluntary. There is no cost to you for participating. You may refuse to participate or discontinue your involvement at any time without penalty. You may choose to skip a question or a study procedure.

- You will not be paid for your participation in this research.

- All research data collected will be stored securely and confidentially in a locked file cabinet in a locked room. Your name and personally identifiable information will not be disclosed. Information (identified by code number only) from this research will be forwarded four times a year to the National Alzheimer’s Coordinating Center (NACC) at the University of Washington, as required by the National Institute on Aging. If existing data is currently available about you that was collected at one of the previous visits but was not reported, it will be de-identified and forwarded to NACC with the above mentioned data.

Approved by IRB on: 11/13/14
HS# 2001-1845
The research team, authorized UCI personnel, the study sponsor, and regulatory entities may have access to your study records to protect your safety and welfare. Any information derived from this research project that personally identifies you will not be voluntarily released or disclosed by these entities without your separate consent, except as specifically required by law.

No one on the study team has a disclosable financial interest related to this research project.

If you have any comments, concerns, or questions regarding the conduct of this research please contact the researchers listed at the top of this form.

If you are unable to reach a member of the research team listed at the top of the form and have general questions, or you have concerns or complaints about the research study, research team, or questions about your rights as a research subject, please contact UCI’s Office of Research by phone, (949) 824-6068 or (949) 824-2125, by e-mail at IRB@rgs.uci.edu or in person at 5171 California Ave., Suite 150, Irvine, CA 92697-7600.
<table>
<thead>
<tr>
<th>Informant Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person requested to complete this questionnaire:</td>
</tr>
<tr>
<td>Last: _________________________ First: _____________________</td>
</tr>
</tbody>
</table>

Please complete the attached questionnaire with the requested information about yourself
Informant Completed By

Informant Information (Please Print * required):

*Last name: _________________________
*First name: _________________________

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

Address: _________________________________________

City: _________________________________________

State: ____ Zipcode: ____________ - __________

Note: Please fill in the following questions about yourself.

<table>
<thead>
<tr>
<th>0) Sex:</th>
<th>1. □ Male</th>
<th>2. □ Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1) Relationship:</th>
<th>1. □ Spouse</th>
<th>11. □ Sibling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10. □ Spouse Equivalent</td>
<td>6. □ Other Relative: ________________</td>
</tr>
<tr>
<td></td>
<td>2. □ Son</td>
<td>7. □ Friend</td>
</tr>
<tr>
<td></td>
<td>4. □ Daughter</td>
<td>9. □ Paid Caregiver / Provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2) Frequency Seen:</th>
<th>1. □ Once or more per day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. □ Several times a week but less than once a day</td>
</tr>
<tr>
<td></td>
<td>3. □ About once per week</td>
</tr>
<tr>
<td></td>
<td>4. □ Less than once a week but two or three times a month</td>
</tr>
<tr>
<td></td>
<td>5. □ Once a month</td>
</tr>
<tr>
<td></td>
<td>6. □ Less than once a month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3) Known for:</th>
<th>1. □ Less than 6 months</th>
<th>2. □ Less than 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3. □ Less than 2 Years</td>
<td>4. □ Less than 5 years</td>
</tr>
<tr>
<td></td>
<td>5. □ Less than 10 years</td>
<td>6. □ Greater than 10 years</td>
</tr>
</tbody>
</table>
Please complete the attached questionnaire with the requested information about the SUBJECT or PATIENT named:

Please indicate the name of the person who is completing this packet about the SUBJECT or PATIENT named ABOVE.

Last Name: _____________________________________

First Name: _____________________________________

Please Enter Date Completed: _______ / _______ / ____________

NOTE: This packet should be completed by someone other than the SUBJECT or PATIENT.
Subject Demographic Information

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

2. A. City or Place of Birth: __________________________
   
   B. Country of Birth: ________________________________

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

Sex:
4. 1. □ Male  2. □ Female  3. □ Transgendered  99. □ Other (specify) _______________________

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)
   
   Asian
   3. □ Asian Indian  8. □ Hmong
   5. □ Chinese  10. □ Laotian
   6. □ Filipino  11. □ Vietnamese
   7. □ Japanese  2. □ Other Asian _____________

   12. □ Black, African-American
   13. □ Caucasian / White
   14. □ Pacific Islander

   99. □ Other Race (specify) _______________________

Handedness:
7. Which is the subject’s dominant hand (i.e., hand used to write or throw with)?
   1. □ Right  2. □ Left  3. □ Both (Ambidextrous)

First Language Learned:
   2. □ Spanish  5. □ Cantonese  99. □ Other (specify) _______________________

Primary Language Spoken:
   2. □ Spanish  5. □ Cantonese  99. □ Other (specify) _______________________
### Subject Demographic Information

#### Sexual Orientation/Identity:

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

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>☐ Heterosexual or straight</td>
</tr>
<tr>
<td>2.</td>
<td>☐ Gay or Lesbian</td>
</tr>
<tr>
<td>3.</td>
<td>☐ Bisexual</td>
</tr>
<tr>
<td>8.</td>
<td>☐ No Answer</td>
</tr>
<tr>
<td>9.</td>
<td>☐ Don’t Know</td>
</tr>
<tr>
<td>99.</td>
<td>☐ Other (specify) ________________</td>
</tr>
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</table>

#### Marital Status:

11.  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1.</td>
<td>☐ Never Married</td>
</tr>
<tr>
<td>2.</td>
<td>☐ Married</td>
</tr>
<tr>
<td>3.</td>
<td>☐ Widowed</td>
</tr>
<tr>
<td>4.</td>
<td>☐ Divorced</td>
</tr>
<tr>
<td>5.</td>
<td>☐ Separated</td>
</tr>
<tr>
<td>6.</td>
<td>☐ Living as Married</td>
</tr>
<tr>
<td>99.</td>
<td>☐ Other (specify) ________________</td>
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</table>

#### Living Situation:

12.  

<p>| | |</p>
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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>☐ Living in household Alone</td>
</tr>
<tr>
<td>2.</td>
<td>☐ Living in household with Spouse / Spouse equivalent only</td>
</tr>
<tr>
<td>3.</td>
<td>☐ Living in household with Relatives</td>
</tr>
<tr>
<td>4.</td>
<td>☐ Living in household with Non-Relatives Only</td>
</tr>
<tr>
<td>5.</td>
<td>☐ Living in Health Related Facility</td>
</tr>
<tr>
<td>6.</td>
<td>☐ Assisted Living Facility</td>
</tr>
<tr>
<td>7.</td>
<td>☐ Retirement Community</td>
</tr>
<tr>
<td>99.</td>
<td>☐ Other (specify) ________________</td>
</tr>
</tbody>
</table>

#### Independence:

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>☐ Able to live independently</td>
</tr>
<tr>
<td>2.</td>
<td>☐ Requires some assistance with complex activities (Finances, Shopping)</td>
</tr>
<tr>
<td>3.</td>
<td>☐ Requires some assistance with basic activities (Eating, Dressing, Bathing)</td>
</tr>
<tr>
<td>4.</td>
<td>☐ Completely dependent</td>
</tr>
</tbody>
</table>

#### Driver’s License:

14.  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>0.</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

Does the subject have a valid driver’s license?

#### Driving Status:

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>☐ Never drove</td>
</tr>
<tr>
<td>2.</td>
<td>☐ Does not drive</td>
</tr>
<tr>
<td>3.</td>
<td>☐ Currently Driving</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>A. If currently driving, how well does the subject drive?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>☐ Drives to previous standards (no problems)</td>
</tr>
<tr>
<td>2.</td>
<td>☐ Drives but needs assistance</td>
</tr>
</tbody>
</table>

If needs assistance, please check all that apply

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1.</td>
<td>☐ Drives but needs assistance with directions</td>
</tr>
<tr>
<td>2.</td>
<td>☐ Drives but has gotten lost multiple times recently</td>
</tr>
<tr>
<td>3.</td>
<td>☐ Drives but has had minor accidents in the last year</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>How many? ________</td>
</tr>
<tr>
<td>4.</td>
<td>☐ Drives but has had to call to get assistance</td>
</tr>
<tr>
<td>5.</td>
<td>☐ Family would not feel safe if they were a passenger in vehicle</td>
</tr>
</tbody>
</table>
Firearms:
16. Are there firearms in the subject’s residence?
   1. □ Yes  0. □ No  9. □ Unknown
   
   A. If 16 is Yes, does the subject have access to them:
   1. □ Yes  0. □ No  9. □ Unknown

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

Occupation:
18. 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:
19. Please indicate highest certificate or degree obtained
    A. 1. □ No Formal Schooling  5. □ Associate / Two-Year College (14 years)
        2. □ Grade School (6 years)  6. □ Bachelors (16 years)
        3. □ Jr. High School (8 years)  7. □ Masters (18 years)
        4. □ High School (12 years)  8. □ Doctorate (20 or more years)
    B. Total Years of Education: ___ ___
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.

<table>
<thead>
<tr>
<th>Birth Year</th>
<th>Check if deceased</th>
<th>Deceased Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mother</td>
<td>__ __ __ __</td>
<td>__ __ __ __</td>
</tr>
<tr>
<td>2. Father</td>
<td>__ __ __ __</td>
<td>__ __ __ __</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Age first noticed</th>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senility or Dementia (example = 82)</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Memory Problems (example = 62)</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Alzheimer’s Disease (example = 67)</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Psychiatric Illness (example = 77)</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Stroke</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Depression</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>□ □ □</td>
</tr>
</tbody>
</table>

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 number of siblings and/or children that were affected by the following conditions.

<table>
<thead>
<tr>
<th>Indicate the total number affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senility or Dementia</td>
</tr>
<tr>
<td>__</td>
</tr>
</tbody>
</table>

7. Siblings __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

8. Children __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Instructions: Please complete the following worksheet pages to the best of your ability. When asked for an age, approximate ages are acceptable. Indicate biological parents that have experienced, or have been diagnosed with the illness listed.

<table>
<thead>
<tr>
<th>Birth Month/Year</th>
<th>Deceased Month/Year</th>
<th>If Present, Indicate Age First Noticed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Memory Problems</td>
</tr>
</tbody>
</table>

Biological Mother

Biological Father

Instructions: Please complete the following worksheet pages to the best of your ability. When asked for an age, approximate ages are acceptable. Indicate full biological siblings that have experienced, or have been diagnosed with the illness listed.

<table>
<thead>
<tr>
<th>Birth Month/Year</th>
<th>Deceased Month/Year</th>
<th>If Present, Indicate Age First Noticed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Memory Problems</td>
</tr>
</tbody>
</table>

Biological Sibling 1

Biological Sibling 2

Biological Sibling 3

Biological Sibling 4

Biological Sibling 5

Biological Sibling 6

Biological Sibling 7

Biological Sibling 8

Biological Sibling 9

Biological Sibling 10
Instructions: Please complete the following worksheet pages to the best of your ability. When asked for an age, approximate ages are acceptable. Indicate full biological children that have experienced, or have been diagnosed with the illness listed.

<table>
<thead>
<tr>
<th>Biological Child 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Month/ Birth Year</td>
<td>Deceased Month/ Deceased Year</td>
<td>If Present, Indicate Age First Noticed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory Problems</td>
<td>Senility or Dementia</td>
<td>Alzheimer’s Disease</td>
<td>Psychiatric Illness</td>
<td>Stroke</td>
<td>Depression</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>Biological Child 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Child 3</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Biological Child 4</td>
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</tr>
<tr>
<td>Biological Child 5</td>
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<td></td>
</tr>
<tr>
<td>Biological Child 6</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Biological Child 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Child 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Child 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Child 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Instructions: Please complete the following medication worksheet to the best of your ability. Please include any prescription medications as well as over-the-counter supplements.

<table>
<thead>
<tr>
<th>Medication or Supplement Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Reason for Starting</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Example: Simvastatin</em></td>
<td>10mg</td>
<td>1 tablet in the morning</td>
<td>Cholesterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 tablet in the evening</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medication Treatment History

**Aricept**

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

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

   If NO, please indication the reason(s) for stopping (check all that apply):
   (1) □ Did not help  (6) □ Diarrhea  (11) □ Nightmares
   (2) □ Abdominal Pain/Cramps  (7) □ Dizziness  (12) □ Nausea
   (3) □ Agitation/Restlessness  (8) □ Fatigue  (13) □ Weight Loss
   (4) □ Anorexia  (9) □ Headache  (14) □ Vomiting
   (5) □ Confusion  (10) □ Insomnia  (99) □ Other: ___________

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

**Exelon Tablets**

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

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

   If NO, please indication the reason(s) for stopping (check all that apply):
   (1) □ Did not help  (6) □ Diarrhea  (11) □ Nightmares
   (2) □ Abdominal Pain/Cramps  (7) □ Dizziness  (12) □ Nausea
   (3) □ Agitation/Restlessness  (8) □ Fatigue  (13) □ Weight Loss
   (4) □ Anorexia  (9) □ Headache  (14) □ Vomiting
   (5) □ Confusion  (10) □ Insomnia  (99) □ Other: ___________

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

**Exelon Patches**

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

   If Yes, then please answer the following:
   A. □ Yes  □ No  Is the subject still using the Exelon Patch?

   If NO, please indication the reason(s) for stopping (check all that apply):
   (1) □ Did not help  (6) □ Diarrhea  (11) □ Nightmares
   (2) □ Abdominal Pain/Cramps  (7) □ Dizziness  (12) □ Nausea
   (3) □ Agitation/Restlessness  (8) □ Fatigue  (13) □ Weight Loss
   (4) □ Anorexia  (9) □ Headache  (14) □ Vomiting
   (5) □ Confusion  (10) □ Insomnia  (99) □ Other: ___________

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

**Razadyne / Reminyl**

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

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

   If NO, please indication the reason(s) for stopping (check all that apply):
   (1) □ Did not help  (6) □ Diarrhea  (11) □ Nightmares
   (2) □ Abdominal Pain/Cramps  (7) □ Dizziness  (12) □ Nausea
   (3) □ Agitation/Restlessness  (8) □ Fatigue  (13) □ Weight Loss
   (4) □ Anorexia  (9) □ Headache  (14) □ Vomiting
   (5) □ Confusion  (10) □ Insomnia  (99) □ Other: ___________

   Please indicated the amount of time Razadyne was used:
   (1) □ < 1 Month  (2) □ 1-2 Months  (3) □ 3-6 Months
   (4) □ 7-12 Months  (5) □ > 12 Months
### Medication Treatment History

**Memantine / Namenda**

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

   If Yes, then please answer the following:

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

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

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

Please indicated the amount of time Namenda was used:

1. □ < 1 Month
2. □ 1-2 months
3. □ 3-6 Months
4. □ 7-12 Months
5. □ > 12 Months
Clinical Trial/Investigational Treatment

1. □ Yes  □ No  Has the subject participated in a clinical trial using an investigational treatment?
   
   If Yes, then please indicate name of study:
   
   __________________________________________________

A. □ Yes  □ No  Is the subject still participating in this study and receiving treatment?

B. Are you aware of whether the subject is receiving:

   (0) □ Placebo   (1) □ Active drug   (9) □ Don’t Know

C. Please indicate the amount of time the subject has been on investigational treatment:

   (1) □ < 1 Month  (2) □ 1-2 months  (3) □ 3-6 Months
   (4) □ 7-12 Months  (5) □ > 12 Months
### 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. □ - Normal, no memory loss
   2. □ - Occasional “benign” forgetfulness of no consequence
   3. □ - Mild consistent forgetfulness with partial recollection of events
   4. □ - Moderate memory loss; more marked for recent events and severe enough to interfere with everyday activities
   5. □ - Severe memory loss, only well-learned material retained with newly learned material rapidly lost
   6. □ - 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. □ - Unable to test due to speech and language difficulty and/or inability to follow instructions
   8. □ - 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. □ - Normal, fully oriented to time and place
   2. □ - Some difficulty with time relationships, but not severe enough to interfere with everyday activities
   3. □ - Frequently disoriented in time and sometimes disoriented to new places
   4. □ - Almost always disoriented in time and usually disoriented to place
   5. □ - 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. □ - Is unaware of questioner and makes no attempt to respond

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

---

**Behavioral Changes (DSRS)**

Institute for Memory Impairments and Neurological Disorders
UDS Revision 1.2 – 2008-07-18 2008©

<table>
<thead>
<tr>
<th>Page</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 of 4</td>
<td>PID:</td>
</tr>
<tr>
<td></td>
<td>Visit:</td>
</tr>
</tbody>
</table>
4. Social Interactions / Community Affairs – Please check only one of the following:

1. □ - Independent function at usual level in job, shopping, volunteer and social groups
2. □ - 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. □ - 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. □ - 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. □ - 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. □ - Normal; life at home, hobbies, intellectual interests are well maintained
2. □ - 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. □ - 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. □ - 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. □ - No significant function in home. No longer engages in any home-based activities

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

1. □ - Normal; fully capable of self-care
2. □ - Needs occasional prompting, but washes and dresses independently (i.e., he/she does most of it, but I help)
3. □ - Requires assistance with dressing, hygiene, and personal upkeep (i.e., I do most of it, but he/she helps)
4. □ - 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. □ - Normal  
2. □ - Occasional difficulty with word finding, but able to carry on conversations  
3. □ - Unable to think of some words, may occasionally make inappropriate word substitutions  
4. □ - No longer spontaneously initiates conversations but can usually answer questions using sentences  
5. □ - Answers questions, but responses are often unintelligible or inappropriate; able to follow simple instructions  
6. □ - Speech usually unintelligible or irrelevant; unable to answer questions or follow verbal instructions  
7. □ - No response when spoken to; vegetative

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

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

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

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

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

1. □ - Normal  
2. □ - Rare incontinence; bladder incontinence (generally less than one accident per month)  
3. □ - Occasional bladder incontinence (an average of two or more times a month)  
4. □ - Frequent bladder incontinence despite assistance (more than once per week)  
5. □ - Total incontinence
11. **Mobility / Walking** – Please check only one of the following:

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

<table>
<thead>
<tr>
<th>All questions require a Single selection to be made.</th>
<th>Normal (0)</th>
<th>Never did, but could do now (8)</th>
<th>Has difficulty, but does by self (or) Never did, but would have difficulty now (1)</th>
<th>Requires Assistance (2)</th>
<th>Dependent on others (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Writing checks, paying bills, balancing a checkbook</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Assembling taxes, managing business affairs, or papers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Shopping alone for clothes, groceries, household necessities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Playing a game or skill, working on a hobby</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Heating water, making a cup of coffee (tea) and turning off stove</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Preparing a balanced meal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Keeping track of current events</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Paying attention and understanding a T.V. program, discussing a book / newspaper article</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Remembering appointments, holidays, family occasions, or medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Driving, traveling out of the neighborhood, arranging to take the bus or a taxi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Name:  
PID:  
Visit:  
Page 1 of 1  
Institute for Memory Impairments and Neurological Disorders  
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### 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. □ Selects and prepares food as required
2. □ Able to prepare food if ingredients are set out for him/her
3. □ Can prepare food if prompted step-by-step
4. □ Unable to prepare food even with prompting and supervision
5. □ Not applicable – never did
6. □ Not applicable – performed by others / this service is provided

#### 2. EATING

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

#### 3. DRINK PREPARATION

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

#### 4. DRINKING

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

#### 5. DRESSING

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

---

**Institute for Memory Impairments and Neurological Disorders**

Core UDS Revision 2.2 – 2005-09-15  2005©

**Name:**

**PID:**

**Visit:**
### 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)

<p>| | | | | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>6. <strong>PERSONAL HYGIENE / GROOMING</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Washes regularly and independently</td>
<td></td>
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<tr>
<td></td>
<td>□ Can wash self if given soap, washcloth, and towel</td>
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<tr>
<td></td>
<td>□ Can wash if prompted and supervised</td>
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<tr>
<td></td>
<td>□ Unable to wash self and needs full assistance</td>
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<tr>
<td>7. <strong>TEETH CLEANING</strong></td>
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<tr>
<td></td>
<td>□ Cleans own teeth/dentures regularly and independently</td>
<td></td>
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<tr>
<td></td>
<td>□ Cleans teeth/dentures if given appropriate items</td>
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<tr>
<td></td>
<td>□ Requires some assistance, toothpaste on brush, brush to mouth, etc.</td>
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<td></td>
<td>□ Full assistance given</td>
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<td>8. <strong>BATHING / SHOWERING</strong></td>
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<tr>
<td></td>
<td>□ Bathes regularly and independently</td>
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<tr>
<td></td>
<td>□ Needs bath to be drawn or shower turned on but washes self independently</td>
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<td></td>
<td>□ Needs supervision and prompting to wash</td>
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<td></td>
<td>□ Totally dependent, needs full assistance</td>
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<td>9. <strong>TOILETING</strong></td>
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<td></td>
<td>□ Uses toilet appropriately when required</td>
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<td></td>
<td>□ Needs to be taken to the toilet and given assistance</td>
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<td></td>
<td>□ Incontinent of urine or feces</td>
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<tr>
<td></td>
<td>□ Incontinent of urine and feces</td>
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<tr>
<td>10. <strong>TRANSFERS</strong></td>
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<tr>
<td></td>
<td>□ Can get in/out of a chair unaided</td>
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<tr>
<td></td>
<td>□ Can get into a chair but needs help to get out</td>
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<tr>
<td></td>
<td>□ Needs help getting in and out of chair</td>
<td></td>
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<tr>
<td></td>
<td>□ Totally dependent on being put into and lifted from chair</td>
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<tr>
<td>11. <strong>MOBILITY</strong></td>
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<tr>
<td></td>
<td>□ Walks independently</td>
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<tr>
<td></td>
<td>□ Walks with assistance (i.e. uses furniture or someone’s arm for support)</td>
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<td></td>
<td>□ Uses physical aids (e.g., walker, cane, sticks) to walk</td>
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<tr>
<td></td>
<td>□ Unable to walk</td>
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<tr>
<td><strong>Bristol Activities of Daily Living Scale (BADLS)</strong> (cont.)</td>
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<tr>
<td><strong>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)</strong></td>
<td></td>
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</tbody>
</table>

### 12. ORIENTATION TO TIME
1. □ Fully oriented to time/day/date etc.
2. □ Unaware of time/day/date etc. but seems unconcerned
3. □ Repeatedly asks the time/day/date
4. □ Mixes up night and day

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

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

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

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

### 17. SHOPPING
1. □ Shops to previous standard
2. □ Only able to shop for 1 or 2 items with or without a list
3. □ Unable to shop alone, but participates when accompanied
4. □ Unable to participate in shopping even when accompanied
5. □ Not applicable – never did
6. □ Not applicable – performed by others / this service is provided
<table>
<thead>
<tr>
<th>18. MANAGING FINANCES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. □ Responsible for own finances at previous level</td>
<td></td>
</tr>
<tr>
<td>2. □ Unable to write check but can sign name and recognizes money values</td>
<td></td>
</tr>
<tr>
<td>3. □ Can sign name but unable to recognize money values</td>
<td></td>
</tr>
<tr>
<td>4. □ Unable to sign name or recognize money values</td>
<td></td>
</tr>
<tr>
<td>5. □ Not applicable – never did</td>
<td></td>
</tr>
<tr>
<td>6. □ Not applicable – performed by others / this service is provided</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>19. GAMES/HOBBIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. □ Participates in pastimes/activities to previous standard</td>
<td></td>
</tr>
<tr>
<td>2. □ Participates but needs instruction/supervision</td>
<td></td>
</tr>
<tr>
<td>3. □ Reluctant to join in, very slow, needs coaxing</td>
<td></td>
</tr>
<tr>
<td>4. □ No longer able or willing to join in, hobbies abandoned</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20. TRANSPORTATION / DRIVING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. □ Able to drive, cycle, or use public transport (e.g., bus, train, taxi) independently</td>
<td></td>
</tr>
<tr>
<td>2. □ Unable to drive, but uses private and public transport or bike independently</td>
<td></td>
</tr>
<tr>
<td>3. □ Can travel with others by car but unable to use public transport on his/her own</td>
<td></td>
</tr>
<tr>
<td>4. □ Unable/unwilling to use private or public transport even when accompanied</td>
<td></td>
</tr>
</tbody>
</table>
Mobility Questionnaire

1. Degree of independence when walking (Please check only one):
   1. □ Normal (i.e., able to walk independently without supervision or assistance)
   2. □ 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. □ Frequently uses a supporting device (cane, walker, etc.) when at home or in the community
   4. □ Requires physical support from others to walk
   5. □ 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. □ Normal (i.e., walks at a relatively brisk pace without obvious signs of fatigue)
   2. □ Only able to walk for short distances (less than 1 city block)
   3. □ 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. □ Unable to walk more than a few steps.

3. Does the patient/subject use any of the following devices?
   1. □ Yes □ No - Cane
      If yes, then □ Chronic (Dependant) □ Acute (Temporary)
   2. □ Yes □ No - Walker
      If yes, then □ Chronic (Dependant) □ Acute (Temporary)
   3. □ Yes □ No - Wheelchair
      If yes, then □ Chronic (Dependant) □ Acute (Temporary)
   4. □ Yes □ No - Shower rails/Bath Chairs
      If yes, then □ Chronic (Dependant) □ Acute (Temporary)

4. Does the patient/subject have difficulty climbing stairs unassisted?
   □ Yes □ No
Sleep Scale

1. How long did it usually take for you to fall asleep during the past 4 weeks? (Check One)
   1. □ 0-15 minutes
   2. □ 16-30 minutes
   3. □ 31-45 minutes
   4. □ 46-60 minutes
   5. □ More than 60 minutes

2. On the average, how many hours did you sleep each night during the past 4 weeks? (Write in number of hours per night)
   ___ ___ (hours)

How often during the past 4 weeks did you...

<table>
<thead>
<tr>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>A Good Bit of the Time</th>
<th>Some of the Time</th>
<th>A Little of the Time</th>
<th>None of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. feel that your sleep was not quiet (moving restlessly, feeling tense, speaking, etc., while sleeping)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. get enough sleep to feel rested upon waking in the morning?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. awaken short of breath or with a headache?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. feel drowsy or sleepy during the day?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. have trouble falling asleep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. awaken during your sleep time and have trouble falling asleep again?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. have trouble staying awake during the day?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. snore during your sleep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. take naps (5 minutes or longer) during the day?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. get the amount of sleep you needed?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>


Sleep Scale

Institute for Memory Impairments and Neurological Disorders
Version 2017-05-31 2017©
### Service Utilization

1. Has the patient, spouse, or a family member contacted any of the following organizations for assistance?
   - [ ] Yes  [ ] No  Alzheimer’s Orange County (AOC)
   - [ ] Yes  [ ] No  Alzheimer’s Association, Orange County Chapter (AAOC)
   - [ ] Yes  [ ] No  Caregiver Resource Center
   - [ ] Yes  [ ] No  Council on Aging

2. [ ] Yes  [ ] No  Has the patient **ever** attended Adult Day Care?

3. [ ] Yes  [ ] No  Is he / she **currently** enrolled in Adult Day Care?
   - If Yes, please indicate the number of days per week: ______

4. [ ] Yes  [ ] No  Is the patient enrolled in the **MediAlert / 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 Financial Affairs**?

6. [ ] Yes  [ ] No  Does the patient have an **Advanced Health Care Directive (ADHC)** or **Durable Power of Attorney for Health Care**?

7. [ ] Yes  [ ] No  Does the patient have a **conservator or guardian**?

8. [ ] Yes  [ ] No  Does the patient have a **paid caregiver and/or homecare aide** providing assistance?
   - If so, how many hours per week? ______ hrs/wk

9. [ ] Yes  [ ] No  Has the primary caregiver or spouse attended a support group?

10. Has the patient, spouse, or family member utilized any of these services?
    - [ ] Yes  [ ] No  **Early Memory Loss Group** through the Alzheimer’s Association (AAOC) or Alzheimer’s Orange County (AOC)
    - [ ] Yes  [ ] No  **Savvy Caregiver Training Program** through the Alzheimer’s Association (AAOC) or Alzheimer’s Orange County (AOC)
    - [ ] Yes  [ ] No  Care Management Services
    - [ ] Yes  [ ] No  Counselor, psychologist, or therapist
    - [ ] Yes  [ ] No  Formal **Driver Safety Evaluation** (such as offered at St. Jude, Hoag Hospital, or the Driving Center)
    - [ ] Yes  [ ] No  **New Connection Club** at Alzheimer’s Services Center in Huntington Beach
    - [ ] Yes  [ ] No  **Mind Boosters** at Alzheimer’s Services Center in Huntington Beach
### Informant/Caregiver Rating of Patient’s Depression

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

<table>
<thead>
<tr>
<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</thead>
</table>
| 1. | | | 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)

<table>
<thead>
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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</table>
| 2. | | | 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)

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<tr>
<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</table>
| 3. | | | Has the patient experienced any changes in weight or appetite?

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<tr>
<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</table>
| a) | | | 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.**

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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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| b) | | | Decrease in appetite nearly every day

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<th>□ Yes</th>
<th>□ No</th>
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</table>
| c) | | | Significant weight gain (e.g., a change of more than 5% of body weight in a month) **How much weight gained? ______ lbs.**

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<th>□ Yes</th>
<th>□ No</th>
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| d) | | | An increase in appetite nearly every day

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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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| 4. | | | How does the patient sleep?

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| a) | □ | Insomnia (too little sleep) nearly every day

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| b) | □ | Hypersomnia (too much sleep) nearly every day

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</table>
| c) | □ | Normal sleeping pattern

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<tr>
<th></th>
<th>□ Yes</th>
<th>□ No</th>
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| 5. | | | Motor restlessness or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slow-down)

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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</table>
| 6. | | | Fatigue or loss of energy nearly every day

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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</table>
| 7. | | | Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</table>
| 8. | | | Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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</table>
| 9. | | | 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

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Institute for Memory Impairments and Neurological Disorders
Core UDS Revision 1.1 – 2005-09-28  2005©
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.
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.

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

☐ Yes (Answer the questions below)

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

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

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

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

Rate the **SEVERITY** of the symptoms (how it affects the subject):
1. ☐ Mild – the delusions are present but seem harmless and produce little distress in the patient; usually managed with redirection or reassurance
2. ☐ Moderate – the delusions are distressing and disruptive to the subject; difficult to alleviate or control.
3. ☐ 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. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ 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.

- ☐ No (Skip to next behavior)
- ☐ Unable to determine (Skip to next behavior)

**□ Yes (Answer the questions below)**

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

- ☐ Describes hearing voices or acts like he/she hears voices
- ☐ Talks to people who are not there
- ☐ 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: ____________________________________________________
- ☐ Reports smelling odors not smelled by others
- ☐ Describes feeling things on his/her skin or otherwise appears to be feeling things crawling or touching him/her
- ☐ Describes tastes that are without any known cause
- ☐ Other unusual sensory experiences
  - Specify: _______________________________________________________

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

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

Rate the **SEVERITY** of the symptoms (how it affects the subject):
1. ☐ Mild – the hallucinations are present but harmless and cause little distress for the patient; usually managed with redirection or reassurance.
2. ☐ Moderate – the hallucinations are distressing and disruptive to the patient; difficult to alleviate or control.
3. ☐ 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. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ 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?

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

☐ Yes (Answer the questions below)

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

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

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

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

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

1. ☐ Mild – the behavior is disruptive but can be managed with redirection or reassurance.
2. ☐ Moderate – the behavior is disruptive and difficult to redirect or control.
3. ☐ 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. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ 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?

- □ No (Skip to next behavior)
- □ Unable to determine (Skip to next behavior)

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

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

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

Rate the **SEVERITY** of the symptoms (how it affects the subject):
1. □ Mild – depression is distressing but usually responds to redirection or reassurance.
2. □ Moderate – depression is distressing to the patient; depressive symptoms are spontaneously voiced by the patient and difficult to alleviate.
3. □ 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 you):
1. □ Not distressing at all
2. □ Minimal – slightly distressing, not a problem to cope with
3. □ Mildly – not very distressing, generally easy to cope with
4. □ Moderate – fairly distressing, not always easy to cope with
5. □ Severe – very distressing, difficult to cope with
6. □ Extreme or Very Severe – extremely distressing, unable to cope with
Personality Changes

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?

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

☐ Yes (Answer the questions below)

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

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

Specify: ____________________________

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

Rate the SEVERITY of the symptoms (how it affects the subject):
1. ☐ Mild – anxiety is distressing but usually responds to redirection or reassurance.
2. ☐ Moderate – anxiety is distressing to the patient; anxiety symptoms are spontaneously voiced by the patient and difficult to alleviate.
3. ☐ 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. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ 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.

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

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

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

  Specify: ___________________________________________

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

Rate the SEVERITY of the symptoms (how it affects the subject):
1. ☐ Mild – elation is notable to friends and family but is not disruptive.
2. ☐ Moderate – elation is notably abnormal and very evident.
3. ☐ 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. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ Extreme or Very Severe – extremely distressing, unable to cope with
Personality Changes

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?

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

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

☐ Less enthusiastic about his/her usual interests
☐ Seems less interested in activities and plans of others
☐ Less likely to initiate conversation
☐ Less affectionate or lacking in emotions when compared to his/her usual self
☐ Contributes less to household chores
☐ Loss interest in friends and family members
☐ Seems less spontaneous and less active than usual
☐ 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. ☐ Occasionally - less than once per week
2. ☐ Often - about once per week
3. ☐ Frequently - several times per week but less than every day
4. ☐ Very frequently – essentially continuously present

Rate the SEVERITY of the symptoms (how it affects the subject):
1. ☐ 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. ☐ 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. ☐ 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. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ Extreme or Very Severe – extremely distressing, unable to cope with

Personality Changes (Apathy/Indifference)

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Revision 2011-02-25
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?

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

Yes (Answer the questions below)

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

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

Rate the FREQUENCY or how often the disinhibition occurs:
1. No – occasionally - less than once per week
2. No – often - about once per week
3. No – frequently - several times per week but less than every day
4. No – very frequently – essentially continuously present

Rate the SEVERITY of the symptoms (how it affects the subject):
1. No – mild – disinhibition is notable but usually responds to redirection and guidance.
2. No – moderate – disinhibition is very evident and difficult to overcome by the caregiver.
3. No – 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 you):
1. Yes – not distressing at all
2. Yes – minimal – slightly distressing, not a problem to cope with
3. Yes – mildly – not very distressing, generally easy to cope with
4. Yes – moderately – fairly distressing, not always easy to cope with
5. Yes – severely – very distressing, difficult to cope with
6. Yes – extremely 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 abnormal irritability, impatience, or rapid emotional changes different from his/her usual self.

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

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

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

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

Rate the SEVERITY of the symptoms (how it affects the subject):
1. ☐ Mild – irritability or lability is notable but usually responds to redirection and reassurance.
2. ☐ Moderate – irritability or lability are very evident and difficult to overcome by the caregiver.
3. ☐ 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 you):
1. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ Extreme or Very Severe – extremely distressing, unable to cope with
Personality Changes

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?

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

☐ Yes (Answer the questions below)

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

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

Specify: ___________________________________________

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

Rate the SEVERITY of the symptoms (how it affects the subject):
1. ☐ Mild – abnormal motor activity is notable but produces little interference with daily routines.
2. ☐ Moderate – abnormal motor activity is very evident; can be overcome by the caregiver.
3. ☐ 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. ☐ Not distressing at all
2. ☐ Minimal – slightly distressing, not a problem to cope with
3. ☐ Mildly – not very distressing, generally easy to cope with
4. ☐ Moderate – fairly distressing, not always easy to cope with
5. ☐ Severe – very distressing, difficult to cope with
6. ☐ Extreme or Very Severe – extremely distressing, unable to cope with
11. Sleep/Nighttime 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?

- [ ] No (Skip to next behavior)
- [ ] Unable to determine (Skip to next behavior)

**Yes (Answer the questions below)**

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

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

Rate the **frequency** or how often the sleep behavior occurs:

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

Rate the **severity** of the symptoms (how it affects the subject):

1. [ ] Mild – nighttime behaviors occur but they are not particularly disruptive.
2. [ ] Moderate – nighttime behaviors occur and disrupt the patient and the sleep of the caregiver; more than one type of nighttime behavior may be present.
3. [ ] Severe – nighttime behaviors occur and are very disruptive; several types of nighttime 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 you):

1. [ ] Not distressing at all
2. [ ] Minimal – slightly distressing, not a problem to cope with
3. [ ] Mildly – not very distressing, generally easy to cope with
4. [ ] Moderate – fairly distressing, not always easy to cope with
5. [ ] Severe – very distressing, difficult to cope with
6. [ ] 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?

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

**Yes (Answer the questions below)**

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

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

Specify: ___________________________________________

Rate the **FREQUENCY** or how often the appetite and eating changes occur:
1. No (Occasionally - less than once per week)
2. Often - about once per week
3. Frequently - several times per week but less than every day
4. Very frequently – essentially continuously present

Rate the **SEVERITY** of the symptoms (how it affects the subject):
1. Mild – changes in appetite or eating are present but have not led to changes in weight and are not disturbing.
2. Moderate – changes in appetite or eating are present and cause minor fluctuations in weight.
3. 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. Not distressing at all
2. Minimal – slightly distressing, not a problem to cope with
3. Mildly – not very distressing, generally easy to cope with
4. Moderately – fairly distressing, not always easy to cope with
5. Severe – very distressing, difficult to cope with
6. Extreme or Very Severe – extremely distressing, unable to cope with
### Neuro Case Summary Worksheet

**Gender:** M / F  **Age:** _______  **Race:** ___________________  **Edu Yrs:** _______

**Gender:** L / R / Both  **Currently Working:**  Y / N  **Occupation:** __________________

**Current Driving:**  Y / N  **If NO:** __________________

**Currently Working:**  Y / N  **Occupation:** ________________  **Retired Year:**  ___________

**Previous Evaluation:**  Y / N  **Physician:** __________________  **Year Seen:**  _____________

**Current:**  MMSE: ____  **GDS:** ____  **Past Diagnosis:** __________________

### HPI:

<table>
<thead>
<tr>
<th>Cognitive Symptoms</th>
<th>Year of Onset</th>
<th>Mode of Onset</th>
<th>Course</th>
<th>New Symptom</th>
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<td>Disorientation</td>
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### 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               |     |     |      |     |      |     |     |     |

Referring MD: __________________________  **Comments:**__________________

Referral Source: __________________________

PCP: __________________________

Consented to:
- Yes □ No Lumbar Puncture
- Yes □ No IPSc (Blood)
- Yes □ No IPSc (Skin)

---

Institute for Memory Impairments and Neurological Disorders
Revision 2014-09-19 2009©
<table>
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<th>Sen/Dem (Age)</th>
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<th>Psych Ill</th>
<th>Depression</th>
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**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

□ Cancer: ______________________

**Sensory Problems**

- Cataracts
- Glaucoma
- Macular degeneration
- Hearing impairment

**Surgical Hx:**  □ No Significant Surgical History

________________________________________________________________________ Date: ___________
________________________________________________________________________ Date: ___________
________________________________________________________________________ Date: ___________

**Habit Hx:**  □ No Significant Habit History

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<tr>
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<td>Yes ☐ No</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

□ Alcohol Abuse
□ Current use
□ Average per week

□ Ever smoke
□ Currently smoking
□ Years smoked
□ Average packs / day
□ Age quit

**Brain Imaging:**

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<th>CT</th>
<th>PET</th>
</tr>
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<tbody>
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<td>Yes ☐ No</td>
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□ DOS: __________ Location: ______________________
□ DOS: __________ Location: ______________________
□ DOS: __________ Location: ______________________

**Labs:**

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<th>CBC</th>
<th>Comp. Met. Panel</th>
<th>TSH</th>
<th>Folate</th>
<th>Vitamin B12</th>
<th>Syphilis Serology</th>
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<td>Yes ☐ No</td>
<td>Yes ☐ No</td>
<td>Yes ☐ No</td>
<td>Yes ☐ No</td>
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□ DOS: __________ Location: ______________________
□ DOS: __________ Location: ______________________
□ DOS: __________ Location: ______________________
□ DOS: __________ Location: ______________________
□ DOS: __________ Location: ______________________

---

Signature ___________________________ Date ___________
Printed Name ___________________________
## 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:

<table>
<thead>
<tr>
<th></th>
<th>Current (w/in 4 weeks)</th>
<th>Has been present since the onset of disorder</th>
<th>Date onset (mm / yyyy)</th>
<th>Onset (circle below)</th>
<th>Course (circle below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4a) Memory</td>
<td>◯  □  O</td>
<td>◯  □  O  ▼</td>
<td>___ / ____</td>
<td>1 2 3 4</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4b) Judgment and problem-solving</td>
<td>◯  □  O</td>
<td>◯  □  O  ▼</td>
<td>___ / ____</td>
<td>1 2 3 4</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4c) Language</td>
<td>◯  □  O</td>
<td>◯  □  O  ▼</td>
<td>___ / ____</td>
<td>1 2 3 4</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4d) Visuospatial function</td>
<td>◯  □  O</td>
<td>◯  □  O  ▼</td>
<td>___ / ____</td>
<td>1 2 3 4</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4e) Getting lost easily</td>
<td>◯  □  O</td>
<td>◯  □  O  ▼</td>
<td>___ / ____</td>
<td>1 2 3 4</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4f) Attention/concentration</td>
<td>◯  □  O</td>
<td>◯  □  O  ▼</td>
<td>___ / ____</td>
<td>1 2 3 4</td>
<td>1 2 3 4 5</td>
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</tbody>
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**History of Present Condition (interview)**

**Completed By (Initials)  Date  Page 1 of 6  Name:**

**PID:**  **Visit:**
**History of Present Condition** (interview)

<table>
<thead>
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<th>COGNITIVE SYMPTOMS:</th>
<th>Current (w/in 4 weeks)</th>
<th>Has been present since the onset of disorder</th>
<th>Date onset (mm / yyyy)</th>
<th>Onset (circle below)</th>
<th>Course (circle below)</th>
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</thead>
<tbody>
<tr>
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<td>Yes</td>
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<td>Unknown</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4g) Fluctuating cognition</td>
<td>☐</td>
<td>□</td>
<td>○</td>
<td>☐</td>
<td>□</td>
</tr>
<tr>
<td>4h) Disorientation to person, place or time</td>
<td>☐</td>
<td>□</td>
<td>○</td>
<td>☐</td>
<td>□</td>
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<tr>
<td>4i) Other (If yes, then specify):</td>
<td>☐</td>
<td>□</td>
<td>○</td>
<td>☐</td>
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</table>

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
<table>
<thead>
<tr>
<th>BEHAVIOR SYMPTOMS:</th>
<th>Current (w/in 4 weeks)</th>
<th>Has been present since the onset of disorder</th>
<th>Date onset (mm / yyyy)</th>
<th>Onset (circle below)</th>
<th>Course (circle below)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yes (1)</td>
<td>No (0)</td>
<td>Unknown (9)</td>
<td>Yes (1)</td>
<td>No (0)</td>
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<tr>
<td>7a) Apathy/withdrawal</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>(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?)</td>
<td></td>
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<tr>
<td>7b) Depression</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>(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?)</td>
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<tr>
<td>7c) Psychosis</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>7c1) Visual hallucination</td>
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<td>7c2) Auditory hallucinations</td>
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<td>7c3) Abnormal/false/delusional beliefs</td>
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<tr>
<td>7d) Disinhibition</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>(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?)</td>
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<td>7e) Irritability</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>(Does the subject overreact, such as shouting at family members or others?)</td>
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<tr>
<td>7f) Agitation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(Does the subject have trouble sitting still; does s/he shout, hit, and/or kick?)</td>
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<tr>
<td>7g) Personality change</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(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?)</td>
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</tbody>
</table>
### History of Present Condition (interview)

**BEHAVIOR SYMPTOMS:**
Indicate whether the subject currently manifests the following behavioral symptoms.

<table>
<thead>
<tr>
<th>BEHAVIOR SYMPTOMS</th>
<th>Current (w/in 4 weeks)</th>
<th>Has been present since the onset of disorder</th>
<th>Date onset (mm / yyyy)</th>
<th>Onset (circle below)</th>
<th>Course (circle below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (1)</td>
<td>No (0)</td>
<td>Unknown (9)</td>
<td>Yes (1)</td>
<td>No (0)</td>
</tr>
<tr>
<td>7h) <strong>REM sleep behavior disorder</strong> (Does the subject appear to act out his/her dreams while sleeping (e.g., punch or flail their arms, shout or scream?)</td>
<td>◯</td>
<td>□</td>
<td>○</td>
<td>◯</td>
<td>□</td>
</tr>
<tr>
<td>7i) <strong>Anxiety</strong> (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?)</td>
<td>◯</td>
<td>□</td>
<td>○</td>
<td>◯</td>
<td>□</td>
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<tr>
<td>7j) <strong>Other</strong> (If yes, then specify):</td>
<td>◯</td>
<td>□</td>
<td>○</td>
<td>◯</td>
<td>□</td>
</tr>
</tbody>
</table>

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)

### MOTOR SYMPTOMS:
Indicate where the subject currently has the following motor symptoms:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Current (w/in 4 weeks)</th>
<th>Has been present since the onset of disorder</th>
<th>Date onset (mm / yyyy)</th>
<th>Onset (circle below)</th>
<th>Course (circle below)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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?)

10b) **Falls** (Does the subject fall more than usual?)

10c) **Tremor** (Has the subject had rhythmic shaking, especially in the hands, arms, legs, head, mouth, or tongue?)

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?)

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)

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

16) ◊ Yes ☐ No  Is there a question about the informant’s reliability?

Comments:
## List of Medications and Supplements:

<table>
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<th>Drug Name</th>
<th># Per Dose</th>
<th>Dose</th>
<th>Unit Code</th>
<th>Freq. Code</th>
<th>Route Code</th>
<th>Mo-Year Started (if unknown enter 9’s)</th>
<th>Reason for Starting</th>
<th>Multum Code</th>
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</tbody>
</table>

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

**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

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

**Drug Code:**
From Multum DB

**Completed By (Initials):**

**Date:**

**Page of:**

**Medication List (time of visit):**

**Institute for Memory Impairments and Neurological Disorders**

Core UDS Revision 1.1 – 7/18/2005 2005

© A.4.1
MEDICATION ALLERGIES

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

If yes, indicate which medications or classes below:

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<th></th>
<th>□ Yes</th>
<th>□ No</th>
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<td>a.</td>
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<td>b.</td>
<td>Cephalosporin</td>
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<td>c.</td>
<td>Sulfa</td>
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<td>d.</td>
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<td>e.</td>
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<td>f.</td>
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<td>k.</td>
<td>Other (List)</td>
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Comments:
# Medical History

## Medical Conditions

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<td>☒</td>
<td>☐</td>
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<td>16</td>
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<td>☒</td>
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<td>17</td>
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<td>☒</td>
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<td>18</td>
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<td>☒</td>
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<td>19</td>
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<td>☒</td>
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<td>Psychiatric</td>
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<td>20</td>
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<td>☒</td>
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<td>21</td>
<td>☐</td>
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<tr>
<td>Alcohol / Substance</td>
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<td>22</td>
<td>☐</td>
<td>☒</td>
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<td>Gastrointestinal</td>
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<td>25</td>
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</tbody>
</table>

## Medical History

**Institute for Memory Impairments and Neurological Disorders**

**Revision 2012-04-06  2009©**

**Page 1 of 3**

**Name:**  
**PID:**  
**Visit:**  
**DOS:**
# Medical History

## Sensory

<table>
<thead>
<tr>
<th>No.</th>
<th>Sensory</th>
<th>Status</th>
<th>MM/YYYY Onset Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Hearing Impairment</td>
<td>□ ◇ ○ □</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Visual Impairment (Non-Correctable)</td>
<td>□ ◇ ○ □</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Glaucoma</td>
<td>□ ◇ ○ □</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Macular Degeneration</td>
<td>□ ◇ ○ □</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Cataracts</td>
<td>□ ◇ ○ □</td>
<td></td>
</tr>
</tbody>
</table>

## Use of Aids

- 32 □ Yes □ No - Wears Hearing Aids
- 33 □ Yes □ No - Wears Glasses or Corrective Lens

## Other Medical Conditions

<table>
<thead>
<tr>
<th>No.</th>
<th>Condition</th>
<th>Status</th>
<th>MM/YYYY Onset Date</th>
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</thead>
<tbody>
<tr>
<td>34</td>
<td>Heart Valve Disease (mitral Valve prolapsed, Aortic Stenosis)</td>
<td>□ ◇ ○ □</td>
<td></td>
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<tr>
<td>35</td>
<td>Congestive Heart Failure</td>
<td>□ ◇ ○ □</td>
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<td>36</td>
<td>Other Heart Conditions (specify):</td>
<td>□ ◇ ○ □</td>
<td></td>
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<tr>
<td>37</td>
<td>Asthma, COPD or other respiratory insufficiency</td>
<td>□ ◇ ○ □</td>
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<td>38</td>
<td>Renal Insufficiency (Kidney problems)</td>
<td>□ ◇ ○ □</td>
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<tr>
<td>39</td>
<td>Hepatic Insufficiency (Liver problems)</td>
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<td>40</td>
<td>Osteoarthritis (Ordinary arthritis)</td>
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<td>Rheumatoid arthritis / Lupus / Scleroderma</td>
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<td>42</td>
<td>Cancer: Breast / Colon / GYN / Prostate / Melanoma / Other:</td>
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<td>43</td>
<td>STD’s</td>
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<td>43a</td>
<td>Syphilis</td>
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<tr>
<td>43b</td>
<td>HIV</td>
<td>□ ◇ ○ □</td>
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<tr>
<td>43c</td>
<td>Hepatitis B</td>
<td>□ ◇ ○ □</td>
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<tr>
<td>43d</td>
<td>Hepatitis C</td>
<td>□ ◇ ○ □</td>
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<td>44</td>
<td>Other Medical:</td>
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## Surgeries

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<tbody>
<tr>
<td>45</td>
<td>Open Heart Surgery / Cardiac Bypass Procedure</td>
<td>□ ◇ ○ □</td>
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<tr>
<td>46</td>
<td>Angioplasty / Endarterectomy / Stent</td>
<td>□ ◇ ○ □</td>
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<tr>
<td>47</td>
<td>Hysterectomy / Oophorectomy</td>
<td>□ ◇ ○ □</td>
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<td>48</td>
<td>Other Surgeries:</td>
<td>□ ◇ ○ □</td>
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</tbody>
</table>

## Hospitalizations

<table>
<thead>
<tr>
<th>No.</th>
<th>Have you been ever been hospitalized, or since your last study evaluation in the last year?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month/Year</td>
<td></td>
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<td></td>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reason</td>
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</tbody>
</table>
### Smoking History

50. □ Yes □ No - Has the subject ever smoked? 
   *(If yes, please answer the following)*
   - □ Yes □ No - Has the subject smoked in the last 30 days?
   - □ Yes □ No - Has the subject quit smoking?
     1) __ __ __ - Age when stopped smoking (999 = unknown)
   - □ __ __ - Total years smoked (99 = unknown)
   - □ __ __ - Has the subject smoked in the last 30 days?
   - □ __ __ - Has the subject quit smoking?

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

### 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 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

   **# of Drinks Per Day (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 3) □ Monthly 
   2) □ Weekly 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?)*
Section I – Interviewer Completes

(1) Explain to the informant that feedback for the reassessment is given via a comprehensive written report. Based on findings, should there be any significant changes in diagnosis or treatment plan the clinicians may recommend a family conference.

☐ Completed

(2) Does the informant report any pressing current needs? ☐ Yes  ☐ No

If yes, describe: ___________________________________________________________

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

Section II – Neurologist or Neuropsychologist Completes During Case Conference

(1) Follow-Up Decision:

☐ Family conference   ☐ Other – Specify: ____________________________

(2) Specific instructions for follow-up: _____________________________________________

_____________________________________________________________

_____________________________________________________________

Section III – Patient Care Coordinator Completes

☐ Family conference scheduled – Date of appointment: _____________

☐ Case referred for follow-up as instructed above – Date completed: _____________
**General Physical**

<table>
<thead>
<tr>
<th>Pulse / Blood Pressure * - Required</th>
<th>Visual Acuity</th>
<th>LT</th>
<th>RT</th>
<th>Height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting: <em>1a) _____ 1a1)<em><strong><strong>/</strong></strong></em></em> W/O Correction: 2a) 20/___ 2a1) 20/___ *3a) __ <strong>.</strong>”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing: 1b) _____ 1b1)<em><strong><strong>/</strong></strong></em>* With Correction: 2b) 20/___ 2b1) 20/___</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supine: 1c) _____ 1c1)<em><strong><strong>/</strong></strong></em>* Both Eyes Together</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*3b) ___ ___ lbs  
*2c) 20/___ 
2d) ☐ Yes ☐ No Corrective Lens Used

1. WNL 2. ABN 3. ND 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 TM clear  
10. Palate, uvula, oropharynx pink, no lesions  
11. Nasal mucosa, septum, turbinate intact  

**Head**
12. 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  

**Abdomen**
23. No murmurs, rubs, gallops  
24. Not distended, bowel sounds normal  
25. No masses, organomegaly  

**Extremities**
26. No deformities, lesions  
27. No edema  
28. Varicosities  
29. Pulses +/-  
30. Dry, intact, no lesions
**Orientation**

“What is today’s date?” Query separately any items not addressed:

What year is it? ______________________________ (If subject only gives the last two digits, ask “What is the full year?”)

What month is it? ______________________________

What day (date) of the month is it? ______________________________

What day of week is it? ______________________________

What season are we in? ______________________________

Scoring: If it is close to the transition between two seasons, accept either season as correct. Seasons change around the 21st of March, June, September, and December. Do not accept "Christmas season"

"Where are we now?” If the patient leaves out certain items ask them separately.

What is the name of this state? ______________________________

What is the name of this county? ______________________________

What city or town are we in? ______________________________

What is the name of this place (building)? ______________________________

What floor are we on? ______________________________

Scoring: UCI is acceptable for ‘place’ but not a more general term like ‘university’ or ‘hospital.’ Acceptable responses for ‘floor’ in the Gottschalk Bldg. include: 1st, main, or ground floor.

**Registration or Immediate Recall**

“Listen carefully. I am going to say three words. After I have said them, I want you to repeat them.”

11 ☐ APPLE 12 ☐ PENNY 13 ☐ TABLE

Alternative set: “Pony, Quarter, Orange” If the examinee is unable to repeat all three on the first trial, continue to repeat them until he/she can repeat all three, up to five trials. The score is based on the number of words repeated on the first trial.

"Remember those three words, because I’m going to ask you to tell me them again in a few minutes.”

(Begin the 3-minute retention interval)

**Attention**

“The word WORLD is spelled “W – O – R – L – D.” Can you spell WORLD backwards?”

14a (D = 1) (L = 1) (R = 1) (O = 1) (W = 1)

Repeat the instructions if the subject asks for a repetition. Allow additional trials if the subject requests them. Record the letters of the subject’s final response. Score one point for each correct letter.

**Delayed Recall**

“What were those three words I asked you to remember earlier?”

15 ☐ APPLE _________ 16 ☐ PENNY _________ 17 ☐ TABLE _________

Do not prompt the examinee or provide any cues or hints. There should be a 3-minute delay between the end of immediate recall and the beginning of delayed recall. Write any incorrect responses in the spaces provided.
**MMSE Record Form**

### Naming
Show the examinee a wristwatch and say: “**What is this?**” Repeat for pencil. If incorrect, record responses.

- 18 [ ] Wristwatch
- 19 [ ] Pencil

### Repetition
“**Now I am going to ask you to repeat exactly what I say. Repeat after me: 'No ifs, ands, or buts.'**

- [ ] Successful
- [ ] Failed

Be sure to articulate the phrase correctly and clearly so that the plural 's' endings are audible. You can repeat the phrase if necessary, but scoring is based only on the first attempt to repeat the phrase. Record the incorrect response.

### Comprehension
“**Listen carefully because I am going to ask you to do something. Take this paper in your right hand, fold it in half, and put it on the floor (or table).**” One repetition of the entire command is permitted.

- 21 [ ] Takes in right hand
- 22 [ ] Folds in half
- 23 [ ] Places on floor (or table)

### Reading & Following Commands
Hold up the paper with the written command and say: “**Please read this and do what is says.**”

- [ ] Closed eyes
- [ ] Did not close eyes

The examinee can be reminded not just to read the read sentence but to obey it. If the examinee is unable to read the sentence due to vision or illiteracy problems, read the sentence out loud.

### Writing
Give the examinee the folded blank sheet of paper used in the verbal comprehension task and a pencil and say: "**Please write a sentence for me.**” [If examinee does not respond, say: Write about the weather.]

- Writes sentence: [ ] Successful
- [ ] Failed

Scoring: Grammar, spelling, and punctuation are not scored. The sentence must contain a subject, verb, and be comprehensible. If it is illegible, ask the examinee to read it aloud for scoring. A sentence with an implied subject (e.g., close the door) is acceptable.

### Construction
Present the examinee with the drawing and say: “**Please copy this design.**”

- Copies Drawing: [ ] Successful
- [ ] Failed

Do not allow erasures. If the examinee is dissatisfied with his/her drawing or requests another attempt, allow him/her to re-draw the figure. Label the first and second attempts. The examinee's drawing must have two 5-sided pentagons which intersect, all 10 angles must be present, and the intersection must result in a four-sided figure.

<table>
<thead>
<tr>
<th>Sc.</th>
<th>Left Pentagon</th>
<th>Sc.</th>
<th>Right Pentagon</th>
<th>Sc.</th>
<th>Intersection</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>5 approximately equal sides</td>
<td>4</td>
<td>5 approximately equal sides</td>
<td>2</td>
<td>4-cornered enclosure</td>
</tr>
<tr>
<td>3</td>
<td>5 but unequal (&gt;2:1) sides</td>
<td>3</td>
<td>5 but unequal (&gt;2:1) sides</td>
<td>1</td>
<td>Not 4-cornered enclosure</td>
</tr>
<tr>
<td>2</td>
<td>Any other enclosed figure</td>
<td>2</td>
<td>Any other enclosed figure</td>
<td>0</td>
<td>No enclosure</td>
</tr>
<tr>
<td>1</td>
<td>&gt;= 2 lines but without closure</td>
<td>1</td>
<td>&gt;= 2 lines but without closure</td>
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<td></td>
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<tr>
<td>0</td>
<td>Less than 2 lines</td>
<td>0</td>
<td>Less than 2 lines</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 27 [ ] Adverse Effect Code
- 28 [ ] Left Pentagon
- 29 [ ] Right Pentagon
- 30 [ ] Intersection
CLOSE YOUR EYES
# Neurological Assessment

**MENTAL STATUS** (higher integrative functions)  

<table>
<thead>
<tr>
<th></th>
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<th>ABN</th>
<th>NT</th>
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<tbody>
<tr>
<td>1.</td>
<td>□</td>
<td>◯</td>
<td>□</td>
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</table>

**ALERTNESS** (Note: Orientation measured by MMSE)  

1a. □ DELIRIUM

<table>
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<th>ABN</th>
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<tbody>
<tr>
<td>2.</td>
<td>□</td>
<td>◯</td>
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</table>

**SPEECH** (including language assessment)

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**MOOD**  

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<th>Present</th>
<th>Absent</th>
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<tr>
<td>3a.</td>
<td>◯</td>
<td>□ DEPRESSION</td>
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**JUDGEMENT**  

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<tr>
<td>4.</td>
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**INSIGHT**

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<tr>
<td>5.</td>
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**CRANIAL NERVES**  

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<tr>
<td>6.</td>
<td>OLFATORY (CN I) (# correct 0-3)</td>
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**Describe Abnormal Findings:**

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<tr>
<td>7.</td>
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**CN II**

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<td>8.</td>
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**CN III, IV, VI**

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**CN V**

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**CN VII**

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<tr>
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<td>◯</td>
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**CN VIII**

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**CN IX, X, XI, XII**

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<th>NT</th>
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<tr>
<td>13.</td>
<td>□</td>
<td>◯</td>
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</tbody>
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**Dysarthria**

<table>
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<tr>
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<tbody>
<tr>
<td>14.</td>
<td>□</td>
<td>◯</td>
<td>□</td>
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**Tongue Protrusion**

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<th>ABN</th>
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</thead>
<tbody>
<tr>
<td>15.</td>
<td>□</td>
<td>◯</td>
<td>□</td>
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**Vertical Limitation of Gaze**

<table>
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<tr>
<td>16.</td>
<td>□</td>
<td>◯</td>
<td>□</td>
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**Horizontal Limitation of Gaze**

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<tr>
<td>17.</td>
<td>□</td>
<td>◯</td>
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**Nystagmus**

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<td>18.</td>
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<td>◯</td>
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**Saccadic Smooth Pursuit**

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<tr>
<td>19.</td>
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<td>◯</td>
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**Difficulty participating in Smooth Pursuit**

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**Masked facies**

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<td>21.</td>
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<td>◯</td>
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</table>
## Neurological Assessment

### Motor System

#### Deep Tendon Reflexes

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>NT</th>
<th>Right</th>
<th></th>
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<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>21a</td>
<td>Absent</td>
<td>Hypo</td>
<td>Hyper</td>
<td>Hyper</td>
<td>Clonus</td>
<td>○</td>
<td></td>
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<tr>
<td>22a</td>
<td>Absent</td>
<td>Hypo</td>
<td>Hyper</td>
<td>Hyper</td>
<td>Clonus</td>
<td>○</td>
<td></td>
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<tr>
<td>23a</td>
<td>Absent</td>
<td>Hypo</td>
<td>Hyper</td>
<td>Hyper</td>
<td>Clonus</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>24a</td>
<td>Absent</td>
<td>Hypo</td>
<td>Hyper</td>
<td>Hyper</td>
<td>Clonus</td>
<td>○</td>
<td></td>
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<tr>
<td>25a</td>
<td>Absent</td>
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<td>Hyper</td>
<td>Hyper</td>
<td>Clonus</td>
<td>○</td>
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#### Pathological Reflexes

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<th></th>
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<th>Present/Abnormal</th>
<th>NT</th>
<th>Right</th>
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<th>Present/Abnormal</th>
<th>NT</th>
<th>Left</th>
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</thead>
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<tr>
<td>26a</td>
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<td>27a</td>
<td>□</td>
<td></td>
<td></td>
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<td>□</td>
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<td>28a</td>
<td>□</td>
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<td></td>
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### Neurological Assessment

***Institute for Memory Impairments and Neurological Disorders***

Revision 2011-02-25  2002

---

**Name:**

**PID:**

**Visit:**

---

**Signature**

**Date**

---

**Page 2 of 4**

---

**Name:**

**PID:**

**Visit:**
### Neurological Assessment

#### Abnormal Movements

<table>
<thead>
<tr>
<th>Right</th>
<th>Upper extremities except where noted</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Absent/Normal Present/Abnormal NT</td>
<td></td>
</tr>
<tr>
<td>30a.</td>
<td>□ ◯ ◯ Pronator Drift</td>
<td></td>
</tr>
<tr>
<td>31a.</td>
<td>□ ◯ ◯ Abnormal Posturing</td>
<td></td>
</tr>
<tr>
<td>32a.</td>
<td>□ ◯ ◯ Myoclonus</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33a.</td>
<td>□ ◯ ◯ Upper extremities</td>
<td></td>
</tr>
<tr>
<td>33b.</td>
<td>□ ◯ ◯ Lower extremities</td>
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</tr>
<tr>
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<td></td>
<td></td>
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<tr>
<td>35a.</td>
<td>□ ◯ ◯ Paramyotonia</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36a.</td>
<td>□ ◯ ◯ Cogwheeling</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>37a.</td>
<td>□ ◯ ◯ Resting Tremors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38a.</td>
<td>□ ◯ ◯ Action Tremors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39a.</td>
<td>□ ◯ ◯ Postural Tremors</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40a.</td>
<td>□ ◯ ◯ Bradykinesia</td>
<td></td>
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<tr>
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<tr>
<td>41.</td>
<td>□ ◯ ◯ Praxis</td>
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<tr>
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<tr>
<td>42.</td>
<td>□ ◯ ◯ Glabellar</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>□ ◯ ◯ Dystonia</td>
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#### UMN Weakness

<table>
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<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>WNL</td>
<td>WNL</td>
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<tr>
<td>NT</td>
<td>NT</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>44a.</td>
<td></td>
</tr>
<tr>
<td>44b.</td>
<td></td>
</tr>
<tr>
<td>45a.</td>
<td></td>
</tr>
<tr>
<td>45b.</td>
<td></td>
</tr>
</tbody>
</table>

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**Signature** ___________________________ **Date** ____________

**Page** 3 of 4

**Name:**

**PID:**

**Visit:**
# Neurological Assessment

## Sensory Evaluation

<table>
<thead>
<tr>
<th>Right</th>
<th>Normal</th>
<th>Decreased</th>
<th>NT</th>
<th>Left</th>
<th>Normal</th>
<th>Decreased</th>
<th>NT</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Romberg Sign**

- **Face**

- **Arms** (Non-glove)

- **Legs** (Non-stocking)

- **Stocking Distribution**

- **Glove Distribution**

- **Vibrations**

## Gait Evaluation

- Absent
- Mild
- Mod
- Severe

<table>
<thead>
<tr>
<th>Gait</th>
<th>Normal</th>
<th>ABN</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Short steps**
- **Shuffle**
- **Lack of arm swing**
- **Circumduction**
- **Flexed / stooped posture**
- **Turns en bloc**
- **Wide-based**
- **Truncal instability**
- **Poor tandem**
- **Retropulsion**

- **Spontaneous**
- **On turns**
- **Sternal nudge**

- **Spastic**

- **Non-neurological/ Orthopedic**

---

**Neurological Assessment**

Name: 

PID:  

Visit: 

Page: 4 of 4

Signature: 

Date: 

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**Clinician Judgment of Motor Symptoms Worksheet**

### Motor symptoms

1. Based on the clinician’s judgment, is the subject currently experiencing any motor symptoms?
   - 0 No (If No, END FORM)
   - 1 Yes

2. Indicate whether the subject currently has meaningful change in motor function in any of the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>No</th>
<th>Yes</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a. Gait disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>2b. Falls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the subject fall more than usual?</td>
<td></td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>2c. Tremor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the subject had rhythmic shaking, especially in the hands, arms, legs, head, mouth, or tongue?</td>
<td></td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>2d. Slowness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the subject noticeably slowed down in walking, moving, or writing by hand, other than due to an injury or illness? Has his/her facial expression changed or become more “wooden,” or masked and unexpressive?</td>
<td></td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

3. Indicate the **predominant** symptom that was first recognized as a decline in the subject’s motor function:
   - 1 Gait disorder
   - 2 Falls
   - 3 Tremor
   - 4 Slowness
   - 99 Unknown

4. Mode of onset of motor symptoms:
   - 1 Gradual
   - 2 Subacute
   - 3 Abrupt
   - 4 Other (SPECIFY): ________________
   - 99 Unknown

5. Were changes in motor function suggestive of parkinsonism?
   - 0 No
   - 1 Yes
   - 9 Unknown
   (If No or Unknown, SKIP TO QUESTION 6)

   5a. If Yes, at what age did the motor symptoms suggestive of parkinsonism begin?
   (The clinician must use his/her best judgment to estimate an age of onset.) __ __ __

6. Were changes in motor function suggestive of amyotrophic lateral sclerosis?
   - 0 No
   - 1 Yes
   - 9 Unknown
   (If No or Unknown, SKIP TO QUESTION 7)

   6a. If Yes, at what age did the motor symptoms suggestive of ALS begin?
   (The clinician must use his/her best judgment to estimate an age of onset.) __ __ __

7. Based on the clinician's assessment, at what age did the motor changes begin?
   (The clinician must use his/her best judgment to estimate an age of onset of motor changes.) __ __ __
Neurologic Diagnosis

Syndrome

1. □ Diagnosis Deferred
2. □ No cognitive Impairment (Normal)
3. □ Questionable Cognitive Impairment (QCI) – Includes AAMI, and ARCD
4. □ Mild Cognitive Impairment (MCI) (Please complete section below)
5. □ Delirium – Impaired attention and disorganized thinking conforming to DMS-IV criteria
6. □ Dementia – Cognitive impairment which conforms to DSM-IV criteria modified to exclude etiology as a criterion (Please complete section below)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Primary</th>
<th>Contributing</th>
<th>Non-Contributing</th>
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</thead>
<tbody>
<tr>
<td>a. □ Alzheimer’s Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. □ Dementia with Lewy bodies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. □ Vascular dementia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. □ Alcohol-related dementia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. □ Dementia of undetermined etiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. □ Frontotemporal dementia (behavioral/executive dementia)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g. □ Primary progressive aphasia (aphasic dementia)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. □ Progressive supranuclear palsy</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>i. □ Corticobasal degeneration</td>
<td></td>
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</tr>
<tr>
<td>j. □ Huntington’s disease</td>
<td></td>
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<tr>
<td>k. □ Prion disease</td>
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</tr>
<tr>
<td>l. □ Cognitive dysfunction from medications</td>
<td></td>
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<tr>
<td>m. □ Cognitive dysfunction from medical illnesses</td>
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<tr>
<td>n. □ Depression</td>
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<tr>
<td>o. □ Other major psychiatric illness</td>
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<td>q. □ Parkinson’s syndrome</td>
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<td>r. □ Stroke</td>
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<td>s. □ Hydrocephalus</td>
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<tr>
<td>t. □ Traumatic brain injury</td>
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<tr>
<td>u. □ CNS neoplasm</td>
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<tr>
<td>v. □ Other (specify): ________________________________________________</td>
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Institute for Memory Impairments and Neurological Disorders
Revision 2016-09-19  2011©

Signature __________________________ Date _______________
### MEDICAL ORDERS

#### Laboratory Tests

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<thead>
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<tr>
<td>Sed Rate</td>
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<td>Urinalysis</td>
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<td>CBC with diff.</td>
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<td>Homocysteine</td>
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<td>Other:</td>
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<td>RPR</td>
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#### Diagnostic Tests

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<tr>
<td>MRI of the Brain w/ or w/o Contrast</td>
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<tr>
<td>Chest X-Ray</td>
<td></td>
<td></td>
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<tr>
<td>CT Scan of the Brain</td>
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<tr>
<td>EKG</td>
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<td>SPECT Scan</td>
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<td>Carotid Doppler</td>
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<td>EEG / EMG</td>
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<tr>
<td>Other:</td>
<td></td>
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</tr>
</tbody>
</table>

#### Consultation:

Reason:

#### Additional Comments:
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. □ Left
   2. □ Right
   3. □ Either
   1a) Based on: ____________________________
3) □ 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. □ 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
(transfer to UDS forms 2.0 C1 Q.11 | 3.0 C1/C2 Q.13a)

Subject Cohort Transition due to current diagnosis
Based on this examination, the subject should be moved from:
5) □ YES □ NO  5) CADC ONLY
5a) □ YES □ NO  ADRC Change Cohort?
   1. □ Control Cohort to Control+MD
   2. □ Control+MD to Patient Cohort
   3. □ Control Cohort to Patient Cohort
   4. □ Patient Cohort to Home (Telephone UDS) Cohort
   5. □ Home (Telephone UDS) Cohort to Home (Mailer Only) Cohort
   6. □ Patient Cohort to Control Cohort

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

Clinician Diagnosis (Supplement)

Completed By (Initials)  Date  Page 1 of 1  Name:
PID:  Visit:
Syndrome

1. □ Diagnosis Deferred (Complete causal factors)
2. □ No Cognitive Impairment (Finished)
3. □ Questionable Cognitive Impairment – Includes AAMI, and ARCD (Finished)
4. □ Delirium – Impaired attention and disorganized thinking conforming to DMS-IV criteria (Complete causal factors, diagnosis, and family history)
5. □ 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. □ Other cognitive impairment not meeting criteria for dementia (Complete causal factors, family history, and the following items)

<table>
<thead>
<tr>
<th></th>
<th>No Impairment (&lt;1 SD)</th>
<th>Mild (≥1 SD, &lt;1.5 SD)</th>
<th>Moderate (≥1.5 SD, &lt;2.0 SD)</th>
<th>Severe (≥ 2.0 SD)</th>
<th>Not Assessed</th>
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<tbody>
<tr>
<td>12a. Memory</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>12b. Executive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>12c. Language</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>12d. Visuospatial</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

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

Consensus Diagnosis

Name: ____________________________
PID: ____________________________
Visit: ____________________________

Neurologist Signature ____________________________  Date ____________

Neuropsychologist Signature ____________________________  Date ____________

Consensus Diagnosis (State)
### Consensus Diagnosis (State)

<table>
<thead>
<tr>
<th>Causal Factors</th>
<th>Causal Factor</th>
<th>13a</th>
<th>13b</th>
<th>13c</th>
<th>13d</th>
<th>13e</th>
<th>13f</th>
<th>13g</th>
<th>13h</th>
<th>13i</th>
<th>13j</th>
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<tr>
<td></td>
<td>Alzheimer’s disease</td>
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<tr>
<td></td>
<td>Cerebrovascular disease</td>
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<tr>
<td></td>
<td>Parkinson’s disease</td>
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<tr>
<td></td>
<td>Lewy Body disease</td>
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<td></td>
<td>Pick’s disease or other frontal temporal syndrome</td>
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<tr>
<td></td>
<td>Progressive supranuclear palsy</td>
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<td>☐</td>
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<tr>
<td></td>
<td>Depressive mood disorder</td>
<td>☐</td>
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<td>Current alcohol use</td>
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<td>Past alcohol use</td>
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### 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.

- Possible AD (NINCDS criteria)
- Probable AD (NINCDS criteria)
- Possible ischemic vascular dementia (ADDTC Criteria)
- Probable ischemic vascular dementia (ADDTC Criteria)
- Cerebrovascular disease not meeting ADDTC criteria for vascular dementia
- Parkinson’s Disease
- Possible dementia with Lewy bodies (DLB consortium criteria)
- Probable dementia with Lewy bodies (DLB consortium criteria)
- Frontal temporal lobe degeneration (FTD consensus criteria)
- Normal pressure hydrocephalus
- Progressive supranuclear palsy
- Depressive mood disorder (DSM-IV criteria)
- Alcohol abuse or dependence (DSM-IV criteria)
- Drug abuse or dependence (DSM-IV criteria)
- Medication (Toxic effect or metabolic derangement)
- Metabolic disorder
- Toxin
- Head trauma
- CNS Infection
- Space-occupying lesion
- Diagnosis undetermined
- Other: _______________________________________________________________

### Consensus Diagnosis

<table>
<thead>
<tr>
<th>Completed By (Initials)</th>
<th>Date</th>
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<th>Name:</th>
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<td>2 of 2</td>
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</tbody>
</table>
## Recommendations Worksheet

### 1) Non-Pharmacological/Behavioral Recommendations
- **AAOC Care Consultant**
- **Adult Day Care**
- **Alternative Living Arrangements**
- **Case Management**
- **Depression**
- **MediAlert /Safe Return**
- **Exercise**
- **New Connections Club (NCC)**
- **“Jumpstart” Program**
- **AAOC Early Memory Loss Group**
- **Psychiatrist**
- **Psychologist / Counseling**
- **Recommend Support Groups**
- **Stop alcohol**
- **Stop smoking**
- **“Savvy” Caregiver Program**

### 2) Legal Recommendations
- **Advance Health Care Directive**
- **DPA Financial Management**
- **Availability of weapons in household**
- **DMV Reporting**
- **Driver Evaluation**
- **Elder Abuse - Caregiver**
- **Elder Abuse - Patient**
- **Elder Law Consultation**

### 3) Medical/Pharmacological Recommendations

<table>
<thead>
<tr>
<th>Drug</th>
<th>Start Dosing</th>
<th>Continue Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aricept</td>
<td>5 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>Exelon (Tablet)</td>
<td>1.5 mg/bid</td>
<td>3 mg/bid</td>
</tr>
<tr>
<td>Exelon (Patch)</td>
<td>4.6 mg</td>
<td>9.5 mg</td>
</tr>
<tr>
<td>Razadyne / Reminyl</td>
<td>4 mg/bid</td>
<td>8 mg/bid</td>
</tr>
<tr>
<td>Razadyne ER</td>
<td>8 mg</td>
<td>16 mg</td>
</tr>
<tr>
<td>Namenda / Memantine</td>
<td>5 mg</td>
<td>10 mg</td>
</tr>
</tbody>
</table>

### 4) Diagnostic Tests Recommendations
- **MRI/CT-Structural Imaging**
- **SPECT/PET – Functional Imaging**

### 5) Clinical Research Study Options
- **Alzheimer’s Disease Neuroimaging Initiative-GO Study**

### 6) Family Conference Neurologist Attendance
- **Yes**
- **No**

Comments:
DRIVER SAFETY

UCI Institute for Memory Impairments and Neurological Disorders
DRIVER SAFETY REPORTING FORM

☐ Not reported (end)

Justification / Comments: ______________________________________________________
_____________________________________________________________________________

☐ Reported (Complete DMV Morbidity Reporting Questions 1-9)

1) If this report is based upon episodic lapses of consciousness, when was the most recent
episode?:
__________________ (mm/dd/yyyy)

2) If there have been multiple episodes of loss of consciousness or control with the past three
years, please indicate the dates if they are known to you.

a) ________________       b) ________________       c) ________________
   (mm/dd/yyyy)           (mm/dd/yyyy)           (mm/dd/yyyy)

3) With the past 12 months, has there been an episode of loss of consciousness or control
while driving?

☐ Yes  ☐ No  ☐ Uncertain

4) Are additional lapses of consciousness likely to occur?

☐ Yes  ☐ No  ☐ Uncertain

5) If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of
consciousness occurring while he/she is awake?

☐ Yes  ☐ No  ☐ Uncertain

6) Has the patient been diagnosed with dementia or Alzheimer’s disease?

☐ Yes  ☐ No  ☐ Uncertain

7) Would you currently advise this patient not to drive because of his/her medical condition:

☐ Yes  ☐ No  ☐ Uncertain

8) Does this patient’s condition represent a permanent driving disability?

☐ Yes  ☐ No  ☐ Uncertain

9) Would you recommend a driving evaluation by DMV?

☐ Yes  ☐ No  ☐ Uncertain

Neurologist Signature:_________________________ Date: __________

Name: ______________________________

Institute for Memory Impairments and Neurological Disorders
Revision 1.0 –04/28/11  2002©
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 the 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.

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<th>PATIENT NAME:</th>
<th>CID #:</th>
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<th>Relationship:</th>
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<tr>
<td>Street:</td>
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<thead>
<tr>
<th>Patient Signature</th>
<th>Date</th>
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</thead>
</table>

Signature of Legally Authorized Representative | Date

Date S.L. Mailed | Date F.C. Mailed
Consent for AAOC Care Consultant Family Conference Participation and Release of Information

One of our recommendations is for you to meet and talk with a care consultant from the Alzheimer’s Association, Orange County Chapter (AAOC). A care consultant is someone with knowledge of a wide variety of community resources and services that may be helpful to those living with and/or providing care for someone with a cognitive impairment. By collaborating with an AAOC care consultant, we are better able to help our patients, family members and/or caregivers fully utilize the services of the Alzheimer’s Association and many other community agencies.

With your permission, we will arrange for an AAOC care consultant/intern to be present at your family conference where the results of your evaluation are reviewed and/or to contact you or your designated family members/caregivers following the conference.

By signing this form, I understand that I am giving permission:

1) For a care consultant/intern from the AAOC to be present at the family conference or to contact me, my designated family members and/or caregivers after I receive the results of my evaluation.

2) For the UCI MIND Clinic to release the following information to the AAOC care consultant/intern, namely (a) my contact information, (b) clinical diagnosis, (c) summary of the cognitive and behavioral findings, and (d) treatment recommendations.

The primary purpose of this information is to facilitate my own and/or my family/caregiver’s utilization of available community services.

I understand that this consent is valid for one year from the date of my signature and that I have the right to revoke this consent at any time.

__________________________  _______________________
Patient Signature                  Date

_____________________________  _______________________
Caregiver, Guardian, or Other Responsible Party Signature  Date

_____________________________  _______________________
Witness                                Date

AAOC Consent 10/22/10  PID: ____________