

# **NACC Uniform Data Set (UDS) FOLLOW-UP VISIT PACKET**

(Version 2.0, February 2008)

*NOTE: Version 2 is NOT the most current version of the UDS forms and is no longer used for data submission. For the most current version, please visit <http://www.alz.washington.edu>.*

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## The National Alzheimer's Coordinating Center (NACC) Uniform Data Set (UDS) Forms for Follow-up Visit Packet (FVP)

The ADC Clinical Task Force requires that the UDS be administered as a standard protocol, separate from protocols that have been developed for administration at individual ADCs. The ADCs may continue to separately administer their site specific protocols to maintain fidelity with data collected prior to the implementation of the UDS and to address research questions that are not addressed by the UDS.

### Typographical Conventions

Instructions will appear as a sans serif font against a shaded background... sample text.

### General Instructions for All Forms

1. Complete the following required information in all form headers:

**Center:** .....Enter the name of the ADC.

**ADC Subject ID:** .....Enter the subject ID used at the ADC. This is the same as the Minimum Data Set (MDS) Patient ID (PTID), if the subject was enrolled in the NACC MDS.

**Form Date:** .....Enter the date that each form was completed at the ADC (mm/dd/yyyy). The Form Date on Form A1 should correspond to the first day of the subject's visit. If the visit takes several days to complete, the Form Date for each form should reflect the date it was completed. For example, if a subject was first seen on January 1, 2006 and forms A1 through B9 were completed, but forms C1 and D1 weren't completed until January 5, 2006, then the Form Date should be entered as "01/01/2006" for forms A1 through B9, and the Form Date for C1 and D1 should be "01/05/2006".

**ADC Visit #:** .....Enter the visit number assigned at the ADC.

**Examiner's initials:** .....Enter the initials for the examiner specified in the form instructions. ("Clinician" includes physicians, PAs, RNs, psychologists, psychometrists and other health professionals specifically trained/certified for patient evaluation or treatment. "ADC staff" refers to any non-clinician at the ADC, typically with some experience conducting research interviews with the specific data collection instrument.)

2. Provide only one answer per question, unless instructed otherwise.
3. Many items include "unknown" as a response category. Use this code only if the respondent is unable or unwilling to provide information that would allow a more specific response.
4. NOTE: Forms A1, A2, A3, A5, and E1 in the Follow-up Visit Packet are modified versions of those included in the Initial Visit Packet, to facilitate collection of data.

Informants are expected for all case and control subjects enrolled in the UDS. Please do your best to identify a reliable informant for the subject. If a local informant is not available, you can contact a long-distance informant. The informant must be one individual (not a group of friends or family members) who is considered the "best" source of information available on the subject. However, in very exceptional instances (e.g., if the subject refuses to supply an informant or there is no information available), the subject can still be enrolled.

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

For forms not designated as required, if it is not feasible to collect all or almost all of the data elements for a subject and the ADC therefore decides not to attempt to collect those data, an explanation must be provided. Please indicate this decision on Form Z1 by including the appropriate explanatory code and any additional comments.



## NACC Uniform Data Set (UDS) Follow-Up Form Z1: Form Checklist

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

**NOTE: This form is to be completed by clinic staff.**

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

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

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

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

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

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

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

**NOTE: This form is to be completed by clinic staff.**

ADC Visit #: \_\_\_\_\_

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

95 = Physical problem

97 = Other problem

96 = Cognitive/behavior problem

98 = Verbal refusal

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

## NACC Uniform Data Set (UDS) Follow-up Form A1: Subject Demographics

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

**NOTE: This form is to be completed by intake interviewer per ADC scheduling records, subject interview, medical records, and proxy informant report (as needed).** ADC Visit #: \_\_\_\_\_  
**For additional clarification and examples, see UDS Coding Guidebook for Follow-up Visit Packet, Form A1. Check only one box per question.** Examiner's initials: \_\_\_\_\_

To print a copy of data collected for this form at previous UDS visit, go to  
<https://www.alz.washington.edu/MEMBER/siteprint.html>.

1. Subject's month/year of birth: ___/____
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2. Subject's sex:	<input type="checkbox"/> 1 Male	<input type="checkbox"/> 2 Female
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3. What is the subject's living situation?	<input type="checkbox"/> 1 Lives alone	<input type="checkbox"/> 4 Lives with group
	<input type="checkbox"/> 2 Lives with spouse or partner	<input type="checkbox"/> 5 Other ( <i>specify</i> ): _____
	<input type="checkbox"/> 3 Lives with relative or friend	<input type="checkbox"/> 9 Unknown

4. What is the subject's level of independence?	<input type="checkbox"/> 1 Able to live independently	<input type="checkbox"/> 3 Requires some assistance with basic activities
	<input type="checkbox"/> 2 Requires some assistance with complex activities	<input type="checkbox"/> 4 Completely dependent
		<input type="checkbox"/> 9 Unknown

5. What is the subject's primary type of residence?	<input type="checkbox"/> 1 Single family residence	<input type="checkbox"/> 4 Skilled nursing facility/ nursing home
	<input type="checkbox"/> 2 Retirement community	<input type="checkbox"/> 5 Other ( <i>specify</i> ): _____
	<input type="checkbox"/> 3 Assisted living/ boarding home/adult family home	<input type="checkbox"/> 9 Unknown

6. Subject's primary residence zip code (first 3 digits):	___ ___ ___ ( <i>leave blank if unknown</i> )
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7. Subject's current marital status:	<input type="checkbox"/> 1 Married	<input type="checkbox"/> 5 Never married
	<input type="checkbox"/> 2 Widowed	<input type="checkbox"/> 6 Living as married
	<input type="checkbox"/> 3 Divorced	<input type="checkbox"/> 8 Other ( <i>specify</i> ): _____
	<input type="checkbox"/> 4 Separated	<input type="checkbox"/> 9 Unknown

## NACC Uniform Data Set (UDS) Follow-up Form A2: Informant Demographics

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

To print a copy of data collected for this form at previous UDS visit, go to  
<https://www.alz.washington.edu/MEMBER/siteprint.html>.

1. Informant's month/year of birth:	<input type="text"/> / <input type="text"/> <small>(99/9999 = Unknown)</small>	
2. Informant's sex:	<input type="checkbox"/> 1 Male	<input type="checkbox"/> 2 Female
3. Is this a new informant? <i>(If no, skip to item #9)</i>	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No
4. Does the informant report being of Hispanic/Latino <u>ethnicity</u> (i.e., having origins from a mainly Spanish-speaking Latin American country), regardless of race?	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown
4a. If yes, what are the informant's reported origins?	<input type="checkbox"/> 1 Mexican/Chicano/ Mexican-American <input type="checkbox"/> 2 Puerto Rican <input type="checkbox"/> 3 Cuban <input type="checkbox"/> 4 Dominican	<input type="checkbox"/> 5 Central American <input type="checkbox"/> 6 South American <input type="checkbox"/> 50 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 99 Unknown
5. What does informant report as his/her race?	<input type="checkbox"/> 1 White <input type="checkbox"/> 2 Black or African American <input type="checkbox"/> 3 American Indian or Alaska Native	<input type="checkbox"/> 4 Native Hawaiian or Other Pacific Islander <input type="checkbox"/> 5 Asian <input type="checkbox"/> 50 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 99 Unknown
6. What additional race does informant report?	<input type="checkbox"/> 1 White <input type="checkbox"/> 2 Black or African American <input type="checkbox"/> 3 American Indian or Alaska Native <input type="checkbox"/> 4 Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> 5 Asian <input type="checkbox"/> 50 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 88 None reported <input type="checkbox"/> 99 Unknown

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

ADC Visit #: \_\_\_\_\_

7. What additional race, beyond what was indicated above in questions 5 and 6, does informant report?	<input type="checkbox"/> 1 White	<input type="checkbox"/> 5 Asian
	<input type="checkbox"/> 2 Black or African American	<input type="checkbox"/> 50 Other ( <i>specify</i> ): _____
	<input type="checkbox"/> 3 American Indian or Alaska Native	<input type="checkbox"/> 88 None reported
	<input type="checkbox"/> 4 Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> 99 Unknown

8. Informant's years of education (report achieved level using the codes below; if an attempted level is not completed, enter the number of years attended). High school/GED = 12; Bachelors degree = 16; Master's degree = 18; Doctorate = 20 years: _____ (99 = Unknown)
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9. What is informant's relationship to subject?	<input type="checkbox"/> 1 Spouse/partner	<input type="checkbox"/> 5 Friend/neighbor
	<input type="checkbox"/> 2 Child	<input type="checkbox"/> 6 Paid caregiver/provider
	<input type="checkbox"/> 3 Sibling	<input type="checkbox"/> 7 Other ( <i>specify</i> ): _____
	<input type="checkbox"/> 4 Other relative	

10. Does the informant live with the subject?	<input type="checkbox"/> 1 Yes (if yes, skip to #11)	<input type="checkbox"/> 0 No
10a. If no, approximate frequency of in-person visits:	<input type="checkbox"/> 1 Daily	<input type="checkbox"/> 4 At least 3x/month
	<input type="checkbox"/> 2 At least 3x/week	<input type="checkbox"/> 5 Monthly
	<input type="checkbox"/> 3 Weekly	<input type="checkbox"/> 6 Less than once a month
10b. If no, approximate frequency of telephone contact:	<input type="checkbox"/> 1 Daily	<input type="checkbox"/> 4 At least 3x/month
	<input type="checkbox"/> 2 At least 3x/week	<input type="checkbox"/> 5 Monthly
	<input type="checkbox"/> 3 Weekly	<input type="checkbox"/> 6 Less than once a month

11. Is there a question about the informant's reliability?	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No
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## NACC Uniform Data Set (UDS) Follow-up Form A3: Subject Family History

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

**NOTE: This form is to be completed by intake interviewer per subject/informant report. For additional clarification and examples, see UDS Coding Guidebook for Follow-up Visit Packet, Form A3.** ADC Visit #: \_\_\_\_\_  
 Examiner's initials: \_\_\_\_\_

**To print a copy of data collected for this form at previous UDS visit, go to  
<https://www.alz.washington.edu/MEMBER/siteprint.html>.**

For the following questions:

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

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

- Review with the subject/informant the data collected for this form at the previous UDS visit. If a version 2.0 Form A3 has been submitted previously and if there have been no changes, check this box and end form here.

**Please consider blood relatives only.**

### PARENTS:

- Provide all information below if it has not been previously submitted. If there has been any change, enter all data in the row for the appropriate parent. Otherwise, check this box and proceed to the next section.

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

### SIBLINGS:

- Provide all information below if it has not been previously submitted. If there has been any change, enter all data in the row for the appropriate sibling. Otherwise, check this box and proceed to the next section.

3. How many full siblings did the subject have? (99 = Unknown) \_\_\_\_

4. For full siblings, indicate the following:

	4a. Year of birth <small>(9999=unknown)</small>	4b. Is the sibling still living?			4c. If deceased, indicate year of death <small>(9999=unknown)</small>	4d. Does/did this sibling have dementia (defined above), as indicated by symptoms, history or diagnosis?			4e. If yes, indicate age at onset <small>(999=unknown)</small>
		Yes	No	Unknown		Yes	No	Unknown	
Sibling 1	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____



**NOTE: This form is to be completed by intake interviewer per subject/informant report. For additional clarification and examples, see UDS Coding Guidebook for Follow-up Visit Packet, Form A3.** ADC Visit #: \_\_\_\_\_

**SIBLINGS:**  
(continued)

	4a.	4b.			4c.	4d.			4e.
	Year of birth <i>(9999=unknown)</i>	Is the sibling still living?			If deceased, indicate year of death <i>(9999=unknown)</i>	Does/did this sibling have dementia (defined above), as indicated by symptoms, history or diagnosis?			If yes, indicate age at onset <i>(999=unknown)</i>
		Yes	No	Unknown		Yes	No	Unknown	
Sibling 2	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 3	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 4	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 5	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 6	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 7	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 8	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 10	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 11	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 12	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 13	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 14	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 15	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 16	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 17	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 18	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 19	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____
Sibling 20	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	_____

**NOTE: This form is to be completed by intake interviewer per subject/informant report. For additional clarification and examples, see UDS Coding Guidebook for Follow-up Visit Packet, Form A3.** ADC Visit #: \_\_\_\_\_

**CHILDREN:**

Provide all information below if it has not been previously submitted. If there has been any change, enter all data in the row for the appropriate child. Otherwise, check this box and proceed to the next section.

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

6. For biological children, indicate the following:

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



## NACC Uniform Data Set (UDS) Follow-up Form A4: Subject Medications

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

**NOTE: The purpose of this form is to record all prescription medications taken by the subject within the two weeks prior to the current visit. OTC/non-prescription medications and vitamins/supplements need not be reported.** ADC Visit #: \_\_\_\_\_

If a medication is not one of the 100 drugs listed below, specify the drug or brand name and determine its drugID by using the Lookup Tool on the NACC website at <https://www.alz.washington.edu/MEMBER/DrugCodeLookup.html>. Examiner's initials: \_\_\_\_\_

Is the subject currently taking any medications?  Yes  No

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

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

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

**NOTE: The purpose of this form is to record all prescription medications taken by the subject within the two weeks prior to the current visit. OTC/non-prescription medications and vitamins/supplements need not be reported.**

ADC Visit #: \_\_\_\_\_

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

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

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

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

ADC Visit #: \_\_\_\_\_

**OTHER DEMENTED RELATIVES:**

Provide all information below if it has not been previously submitted. If there has been any change, enter all data in the row for the appropriate relative. Otherwise, check this box and end form here.

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

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

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

## NACC Uniform Data Set (UDS) Follow-up Form A5: Subject Health History

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

To print a copy of data collected for this form at previous UDS visit, go to  
<https://www.alz.washington.edu/MEMBER/siteprint.html>.

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

1. Cardiovascular disease	Absent	Active	Inactive	Unknown
a. Heart attack/cardiac arrest	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
b. Atrial fibrillation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
c. Angioplasty/endarterectomy/stent	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
d. Cardiac bypass procedure	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
e. Pacemaker	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
f. Congestive heart failure	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
g. Other ( <i>specify</i> ): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

2. Cerebrovascular disease	Absent	Active	Inactive	Unknown
a. Stroke	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
If active, indicate year(s) in which this occurred: (9999 = Year unknown)	1) _____	2) _____	3) _____	
	4) _____	5) _____	6) _____	
b. Transient ischemic attack	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
If active, indicate year(s) in which this occurred: (9999 = Year unknown)	1) _____	2) _____	3) _____	
	4) _____	5) _____	6) _____	
c. Other ( <i>specify</i> ): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

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

ADC Visit #: \_\_\_\_

3. Parkinsonian features	Absent	Active	Unknown
a. Parkinson's disease	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
If active, indicate year of diagnosis: (9999 = Year unknown) _____			
b. Other Parkinsonism disorder	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
If active, indicate year of diagnosis: (9999 = Year unknown) _____			

4. Other neurologic conditions	Absent	Active	Inactive	Unknown
a. Seizures	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
b. Traumatic brain injury				
1) with brief loss of consciousness (< 5 minutes)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
2) with extended loss of consciousness (≥ 5 minutes)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
3) with chronic deficit or dysfunction	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
c. Other ( <i>specify</i> ): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

5. Medical/metabolic conditions	Absent	Active	Inactive	Unknown
a. Hypertension	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
b. Hypercholesterolemia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
c. Diabetes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
d. B12 deficiency	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
e. Thyroid disease	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
f. Incontinence – urinary	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
g. Incontinence – bowel	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9

6. Depression	No	Yes	Unknown
a. Active within past 2 years	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
b. Other episodes (prior to 2 years)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9

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

ADC Visit #: \_\_\_ \_\_\_

7. Substance abuse and psychiatric disorders					
a. Substance abuse – alcohol		<b>Absent</b>	<b>Active</b>	<b>Inactive</b>	<b>Unknown</b>
1) Clinically significant impairment occurring over a 12-month period manifested in one of the following: work, driving, legal or social.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	

b. Cigarette smoking history		<b>No</b>	<b>Yes</b>	<b>Unknown</b>
1) Has subject smoked within last 30 days?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9	
2) Has subject smoked more than 100 cigarettes in his/her life?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9	
3) Total years smoked: (88 = N/A; 99 = Unknown) _____				
4) Average number of packs/day smoked:	<input type="checkbox"/> 1 1 cigarette – < ½ pack	<input type="checkbox"/> 4 1½ – < 2 packs	<input type="checkbox"/> 9 Unknown	
	<input type="checkbox"/> 2 ½ – < 1 pack	<input type="checkbox"/> 5 ≥ 2 packs		
	<input type="checkbox"/> 3 1 – < 1½ pack	<input type="checkbox"/> 8 N/A		
5) If subject quit smoking, specify age when last smoked (i.e., quit): (888 = N/A; 999 = Unknown) _____				

c. Other abused substances		<b>Absent</b>	<b>Active</b>	<b>Inactive</b>	<b>Unknown</b>
1) Clinically significant impairment occurring over a 12-month period manifested in one of the following: work, driving, legal or social.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	
If active or inactive, specify abused substance(s): _____					

d. Psychiatric disorders	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9
If active or inactive, specify disorder(s): _____				





**NACC Uniform Data Set (UDS)  
 Follow-up Form B1: Evaluation Form – Physical**

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

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

ADDITIONAL PHYSICAL OBSERVATIONS	Yes	No	Unknown
5. Without corrective lenses, is the subject's vision functionally normal?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
6. Does the subject usually wear corrective lenses?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
6a. If yes, is the subject's vision functionally normal <u>with</u> corrective lenses?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

7. Without a hearing aid(s), is the subject's hearing functionally normal?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
8. Does the subject usually wear a hearing aid(s)?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
8a. If yes, is the subject's hearing functionally normal <u>with</u> a hearing aid(s)?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

**NACC Uniform Data Set (UDS)  
 Follow-up Form B2: Evaluation Form – HIS and CVD**

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

<b>HACHINSKI ISCHEMIC SCORE <sup>1</sup></b>		
Please complete the following scale using information obtained from history/physical/neurological exam and/or medical records. Circle the appropriate value to indicate if a specific item is present ( <u>characteristic of the patient</u> ) or absent.		
	<b>Present</b>	<b>Absent</b>
1. Abrupt onset (re: cognitive status)	2	0
2. Stepwise deterioration (re: cognitive status)	1	0
3. Somatic complaints	1	0
4. Emotional incontinence	1	0
5. History or presence of hypertension	1	0
6. History of stroke	2	0
7. Focal neurological symptoms	2	0
8. Focal neurological signs	2	0
<b>9. Sum all circled answers for a Total Score:</b>	— —	

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

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

ADC Visit #: \_\_\_\_\_

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



**NACC Uniform Data Set (UDS)**  
**Follow-up Form B3: Evaluation Form –**  
**Unified Parkinson's Disease Rating Scale (UPDRS<sup>1</sup>) – Motor Exam**

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

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

[Optional] If the clinician completes the UPDRS examination and determines all items are normal, check this box and end form here.

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

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

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

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

ADC Visit #: \_\_\_\_\_

3c. Left hand	<input type="checkbox"/> 0 Absent. <input type="checkbox"/> 1 Slight and infrequently present. <input type="checkbox"/> 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	<input type="checkbox"/> 3 Moderate in amplitude and present most of the time. <input type="checkbox"/> 4 Marked in amplitude and present most of the time. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____
3d. Right foot	<input type="checkbox"/> 0 Absent. <input type="checkbox"/> 1 Slight and infrequently present. <input type="checkbox"/> 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	<input type="checkbox"/> 3 Moderate in amplitude and present most of the time. <input type="checkbox"/> 4 Marked in amplitude and present most of the time. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____
3e. Left foot	<input type="checkbox"/> 0 Absent. <input type="checkbox"/> 1 Slight and infrequently present. <input type="checkbox"/> 2 Mild in amplitude and persistent; or moderate in amplitude, but only intermittently present.	<input type="checkbox"/> 3 Moderate in amplitude and present most of the time. <input type="checkbox"/> 4 Marked in amplitude and present most of the time. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

4. Action or postural tremor of hands		
4a. Right hand	<input type="checkbox"/> 0 Absent. <input type="checkbox"/> 1 Slight; present with action. <input type="checkbox"/> 2 Moderate in amplitude, present with action.	<input type="checkbox"/> 3 Moderate in amplitude with posture holding as well as action. <input type="checkbox"/> 4 Marked in amplitude; interferes with feeding. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____
4b. Left hand	<input type="checkbox"/> 0 Absent. <input type="checkbox"/> 1 Slight; present with action. <input type="checkbox"/> 2 Moderate in amplitude, present with action.	<input type="checkbox"/> 3 Moderate in amplitude with posture holding as well as action. <input type="checkbox"/> 4 Marked in amplitude; interferes with feeding. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

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

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

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

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

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

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

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

8. Rapid alternating movements of hands (pronation-supination movements of hands, vertically and horizontally, with as large an amplitude as possible, both hands simultaneously)		
8a. Right hand	<input type="checkbox"/> 0 Normal. <input type="checkbox"/> 1 Mild slowing and/or reduction in amplitude. <input type="checkbox"/> 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	<input type="checkbox"/> 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. <input type="checkbox"/> 4 Can barely perform the task. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____
8b. Left hand	<input type="checkbox"/> 0 Normal. <input type="checkbox"/> 1 Mild slowing and/or reduction in amplitude. <input type="checkbox"/> 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	<input type="checkbox"/> 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. <input type="checkbox"/> 4 Can barely perform the task. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

9. Leg agility (patient taps heel on the ground in rapid succession, picking up entire leg; amplitude should be at least 3 inches)		
9a. Right leg	<input type="checkbox"/> 0 Normal. <input type="checkbox"/> 1 Mild slowing and/or reduction in amplitude. <input type="checkbox"/> 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	<input type="checkbox"/> 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. <input type="checkbox"/> 4 Can barely perform the task. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____
9b. Left leg	<input type="checkbox"/> 0 Normal. <input type="checkbox"/> 1 Mild slowing and/or reduction in amplitude. <input type="checkbox"/> 2 Moderately impaired; definite and early fatiguing; may have occasional arrests in movement.	<input type="checkbox"/> 3 Severely impaired; frequent hesitation in initiating movements or arrests in ongoing movement. <input type="checkbox"/> 4 Can barely perform the task. <input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

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

ADC Visit #: \_\_\_\_\_

10. Arising from chair (patient attempts to rise from a straight-backed chair, with arms folded across chest)	<input type="checkbox"/> 0 Normal.	<input type="checkbox"/> 3 Tends to fall back and may have to try more than one time, but can get up without help.
	<input type="checkbox"/> 1 Slow; or may need more than one attempt.	<input type="checkbox"/> 4 Unable to arise without help.
	<input type="checkbox"/> 2 Pushes self up from arms of seat.	<input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

11. Posture	<input type="checkbox"/> 0 Normal.	<input type="checkbox"/> 3 Severely stooped posture with kyphosis; can be moderately leaning to one side.
	<input type="checkbox"/> 1 Not quite erect, slightly stooped posture; could be normal for older person.	<input type="checkbox"/> 4 Marked flexion with extreme abnormality of posture.
	<input type="checkbox"/> 2 Moderately stooped posture, definitely abnormal; can be slightly leaning to one side.	<input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

12. Gait	<input type="checkbox"/> 0 Normal.	<input type="checkbox"/> 3 Severe disturbance of gait requiring assistance.
	<input type="checkbox"/> 1 Walks slowly; may shuffle with short steps, but no festination (hastening steps) or propulsion.	<input type="checkbox"/> 4 Cannot walk at all, even with assistance.
	<input type="checkbox"/> 2 Walks with difficulty, but requires little or no assistance; may have some festination, short steps, or propulsion.	<input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

13. Posture stability (response to sudden, strong posterior displacement produced by pull on shoulders while patient erect with eyes open and feet slightly apart; patient is prepared)	<input type="checkbox"/> 0 Normal erect.	<input type="checkbox"/> 3 Very unstable, tends to lose balance spontaneously.
	<input type="checkbox"/> 1 Retropulsion, but recovers unaided.	<input type="checkbox"/> 4 Unable to stand without assistance.
	<input type="checkbox"/> 2 Absence of postural response; would fall if not caught by examiner.	<input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____

14. Body bradykinesia and hypokinesia (combining slowness, hesitancy, decreased arm swing, small amplitude, and poverty of movement in general)	<input type="checkbox"/> 0 None.	<input type="checkbox"/> 3 Moderate slowness, poverty or small amplitude of movement.
	<input type="checkbox"/> 1 Minimal slowness, giving movement a deliberate character; could be normal for some persons; possibly reduced amplitude.	<input type="checkbox"/> 4 Marked slowness, poverty or small amplitude of movement.
	<input type="checkbox"/> 2 Mild degree of slowness and poverty of movement which is definitely abnormal. Alternatively, some reduced amplitude.	<input type="checkbox"/> 8 Untestable ( <i>specify reason</i> ): _____



**NACC Uniform Data Set (UDS)**

**Follow-up Form B4: Global Staging – Clinical Dementia Rating (CDR): Standard and Supplemental**

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

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

Examiner's initials: \_\_\_\_\_

**SECTION 1: STANDARD CDR <sup>1</sup>**

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

<sup>1</sup> Morris JC. The Clinical Dementia Rating (CDR): Current version and scoring rules. *Neurology* 43(11):2412-4, 1993. Copyright© Lippincott, Williams & Wilkins. Reproduced by permission. (version 2.0, February 2008)

Center: \_\_\_\_\_

ADC Subject ID: \_\_\_\_\_

Form Date: \_\_\_/\_\_\_/\_\_\_\_\_

ADC Visit #: \_\_\_\_\_

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

## SECTION 2: SUPPLEMENTAL CDR

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

<sup>2</sup> Excerpted from the Frontotemporal Dementia Multicenter Instrument & MR Study (Mayo Clinic, UCSF, UCLA, UW).

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

## NACC Uniform Data Set (UDS) Follow-up Form B5: Behavioral Assessment – Neuropsychiatric Inventory Questionnaire (NPI-Q<sup>1</sup>)

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

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

Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no".  
 For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient):  
 1 = Mild (noticeable, but not a significant change)  
 2 = Moderate (significant, but not a dramatic change)  
 3 = Severe (very marked or prominent; a dramatic change)

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

<sup>1</sup> Copyright© Jeffrey L. Cummings, MD. Reproduced by permission.

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

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

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

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

**NACC Uniform Data Set (UDS)**

**Follow-up Form B6: Behavioral Assessment – Geriatric Depression Scale (GDS)<sup>1</sup>**

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

**NOTE: This form is to be completed by the clinician or other trained health professional,** ADC Visit #: \_\_\_\_\_  
**based on subject response. For additional clarification and examples, see UDS Coding**  
**Guidebook for Follow-up Visit Packet, Form B6. Circle only one number per question.** Examiner's initials: \_\_\_\_\_

Check this box and enter "88" below for the Total GDS Score if and only if the subject: 1) does not attempt the GDS, or 2) answers fewer than twelve questions.

**Instruct the subject:** "In the next part of this interview, I will ask you questions about your feelings. Some of the questions I will ask you may not apply, and some may make you feel uncomfortable. For each question, please answer "yes" or "no", depending on how you have been feeling **in the past week, including today.**"

	Yes	No
1. Are you basically satisfied with your life?	0	1
2. Have you dropped many of your activities and interests?	1	0
3. Do you feel that your life is empty?	1	0
4. Do you often get bored?	1	0
5. Are you in good spirits most of the time?	0	1
6. Are you afraid that something bad is going to happen to you?	1	0
7. Do you feel happy most of the time?	0	1
8. Do you often feel helpless?	1	0
9. Do you prefer to stay at home, rather than going out and doing new things?	1	0
10. Do you feel you have more problems with memory than most?	1	0
11. Do you think it is wonderful to be alive now?	0	1
12. Do you feel pretty worthless the way you are now?	1	0
13. Do you feel full of energy?	0	1
14. Do you feel that your situation is hopeless?	1	0
15. Do you think that most people are better off than you are?	1	0
<b>16. Sum all circled answers for a Total GDS Score</b> (maximum score = 15) (did not complete = 88)	—	—

<sup>1</sup> Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. Clinical Gerontology: A Guide to Assessment and Intervention 165-173, NY: The Haworth Press, 1986. Reproduced by permission of the publisher.

## NACC Uniform Data Set (UDS) Follow-up Form B7: Functional Assessment – Functional Assessment Questionnaire (FAQ<sup>1</sup>)

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

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

Examiner's initials: \_\_\_\_\_

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

<sup>1</sup> Pfeffer RI, Kurosaki TT, Harrah CH, et al. Measurement of functional activities of older adults in the community. *J Gerontol* 37:323-9, 1982. Copyright© 1982. The Gerontological Society of America. Reproduced by permission of the publisher.



**NACC Uniform Data Set (UDS)**

**Follow-up Form B8: Evaluation – Physical/Neurological Exam Findings**

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

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



## NACC Uniform Data Set (UDS) Follow-up Form B9: Clinician Judgment of Symptoms

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

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

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



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

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

<b>BEHAVIOR SYMPTOMS:</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
7. Indicate whether the subject currently manifests the following behavioral symptoms:			
a. <b>Apathy/withdrawal</b> (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?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
b. <b>Depression</b> (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?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
c. <b>Psychosis</b>			
1) Visual hallucinations	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
a) If yes, are the hallucinations well-formed and detailed?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
2) Auditory hallucinations	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
3) Abnormal/false/delusional beliefs	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
d. <b>Disinhibition</b> (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?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
e. <b>Irritability</b> (Does the subject overreact, such as shouting at family members or others?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
f. <b>Agitation</b> (Does the subject have trouble sitting still; does s/he shout, hit, and/or kick?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
g. <b>Personality change</b> (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?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
h. <b>REM sleep behavior disorder</b> (Does the subject appear to act out his/her dreams while sleeping (e.g., punch or flail their arms, shout or scream?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
i. <b>Other</b> ( <i>If yes, then specify</i> ): _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

*(continued on next page)*

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

8. Indicate the <u>predominant</u> symptom which was first recognized as a decline in the subject's behavioral symptoms:	<input type="checkbox"/> 1 Apathy/withdrawal <input type="checkbox"/> 2 Depression <input type="checkbox"/> 3 Psychosis <input type="checkbox"/> 4 Disinhibition <input type="checkbox"/> 5 Irritability <input type="checkbox"/> 6 Agitation	<input type="checkbox"/> 7 Personality change <input type="checkbox"/> 8 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 9 REM sleep behavior disorder <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown
9. Mode of onset of behavioral symptoms:	<input type="checkbox"/> 1 Gradual (> 6 months) <input type="checkbox"/> 2 Subacute (≤ 6 months) <input type="checkbox"/> 3 Abrupt ( <i>within days</i> )	<input type="checkbox"/> 4 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown

<b>MOTOR SYMPTOMS:</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
10. Indicate whether the subject currently has the following motor symptoms:			
a. <b>Gait disorder</b> (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?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
b. <b>Falls</b> (Does the subject fall more than usual?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
c. <b>Tremor</b> (Has the subject had rhythmic shaking, especially in the hands, arms, legs, head, mouth, or tongue?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
d. <b>Slowness</b> (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?)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
11. Indicate the <u>predominant</u> symptom which was first recognized as a decline in the subject's motor symptoms:	<input type="checkbox"/> 1 Gait disorder <input type="checkbox"/> 2 Falls <input type="checkbox"/> 3 Tremor	<input type="checkbox"/> 4 Slowness <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown	
12. Mode of onset of motor symptoms:	<input type="checkbox"/> 1 Gradual (> 6 months) <input type="checkbox"/> 2 Subacute (≤ 6 months) <input type="checkbox"/> 3 Abrupt ( <i>within days</i> )	<input type="checkbox"/> 4 Other ( <i>specify</i> ): _____ <input type="checkbox"/> 88 N/A <input type="checkbox"/> 99 Unknown	
a. If there were changes in motor function, were these suggestive of parkinsonism?	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 88 N/A		

<b>OVERALL SUMMARY OF SYMPTOMS ONSET:</b>			
13. Course of overall cognitive/behavioral/motor syndrome:	<input type="checkbox"/> 1 Gradually progressive <input type="checkbox"/> 2 Stepwise <input type="checkbox"/> 3 Static	<input type="checkbox"/> 4 Fluctuating <input type="checkbox"/> 5 Improved <input type="checkbox"/> 9 Unknown	
14. Indicate the <u>predominant</u> domain which was first recognized as changed in the subject:	<input type="checkbox"/> 1 Cognition <input type="checkbox"/> 2 Behavior	<input type="checkbox"/> 3 Motor function <input type="checkbox"/> 9 Unknown	



**NACC Uniform Data Set (UDS)**

**Follow-up Form C1: MMSE and Neuropsychological Battery**

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

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

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

<b>1. Mini-Mental State Examination</b>			
1a. The administration of the MMSE was:	<input type="checkbox"/> 1 In ADC/clinic	<input type="checkbox"/> 2 In home	<input type="checkbox"/> 3 In person—other
1) Language of MMSE administration:	<input type="checkbox"/> 1 English	<input type="checkbox"/> 2 Spanish	<input type="checkbox"/> 3 Other ( <i>specify</i> ): _____
1b. Orientation subscale score			
1) Time:	___	(0–5) <i>see Key</i>	
2) Place:	___	(0–5) <i>see Key</i>	
1c. Intersecting pentagon subscale score:	___	(0–1) <i>see Key</i>	
1d. Total MMSE score (using D-L-R-O-W)	___	(0–30) <i>see Key</i>	

<b>2. The remainder of the battery (below) was administered:</b>			
	<input type="checkbox"/> 1 In ADC/clinic	<input type="checkbox"/> 2 In home	<input type="checkbox"/> 3 In person—other
2a. Language of test administration:	<input type="checkbox"/> 1 English	<input type="checkbox"/> 2 Spanish	<input type="checkbox"/> 3 Other ( <i>specify</i> ): _____

<b>3. Logical Memory IA – Immediate</b>			
3a. If this test has been administered to the subject within the past 3 months, specify the date previously administered:	___/___/_____	(88/88/8888 = N/A)	
1) Total score from the previous test administration:	___	(0–25; 88 = N/A)	
3b. Total number of story units recalled from this current test administration:	___	(0–25) <i>see Key</i>	
<b>4. Digit Span Forward</b>			
4a. Total number of trials correct prior to two consecutive errors at the same digit length:	___	(0–12) <i>see Key</i>	
4b. Digit span forward length:	___	(0–8) <i>see Key</i>	

**NOTE: This form is to be completed by ADC or clinic staff. For test administration and scoring, see UDS Coding Guidebook for Follow-up Visit Packet, Form C1.** ADC Visit #: \_\_\_\_\_

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

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

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

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

Check only one box below:

<b>11. Overall Appraisal</b>		
11a. Based on the UDS neuropsychological examination, the subject's cognitive status is deemed:	<input type="checkbox"/> 1 Better than normal for age <input type="checkbox"/> 2 Normal for age <input type="checkbox"/> 3 One or two test scores abnormal	<input type="checkbox"/> 4 Three or more scores are abnormal or lower than expected <input type="checkbox"/> 0 Clinician unable to render opinion

**NACC Uniform Data Set (UDS)**

**Follow-up Form D1: Clinician Diagnosis – Cognitive Status and Dementia**

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

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

2. Does the subject have normal cognition (no MCI, dementia, or other neurological condition resulting in cognitive impairment)?       1 Yes (If yes, skip to #14)       0 No (If no, continue to #3)

3. Does the subject meet criteria for dementia (in accordance with standard criteria for dementia of the Alzheimer's type or for other non-Alzheimer's dementing disorders)?       1 Yes (If yes, skip to #5)       0 No (If no, continue to #4)

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

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

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

ADC Visit #: \_\_\_\_\_

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

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

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

ADC Visit #: \_\_\_\_\_

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

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

## NACC Uniform Data Set (UDS) Follow-up Form E1: Imaging/Labs

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

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

ADC Visit #: \_\_\_\_\_

Examiner's initials: \_\_\_\_\_

To print a copy of data collected for this form at previous UDS visit, go to  
<https://www.alz.washington.edu/MEMBER/siteprint.html>.

**Since the last visit, has neuroimaging been completed and available at your ADC?**

	Film		Digital image	
	Yes	No	Yes	No
1. Computed tomography	1a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	1b. <input type="checkbox"/> 1	<input type="checkbox"/> 0
2. Magnetic resonance imaging – Clinical study	2a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	2b. <input type="checkbox"/> 1	<input type="checkbox"/> 0
3. Magnetic resonance imaging – Research study/structural	3a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	3b. <input type="checkbox"/> 1	<input type="checkbox"/> 0
4. Magnetic resonance imaging – Research study/functional	4a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	4b. <input type="checkbox"/> 1	<input type="checkbox"/> 0
5. Magnetic resonance spectroscopy	5a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	5b. <input type="checkbox"/> 1	<input type="checkbox"/> 0
6. SPECT	6a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	6b. <input type="checkbox"/> 1	<input type="checkbox"/> 0
7. PET	7a. <input type="checkbox"/> 1	<input type="checkbox"/> 0	7b. <input type="checkbox"/> 1	<input type="checkbox"/> 0

**Are specimens of the following available at your ADC?**

	Yes	No
8. DNA	<input type="checkbox"/> 1	<input type="checkbox"/> 0
9. Cerebrospinal fluid – ante-mortem	<input type="checkbox"/> 1	<input type="checkbox"/> 0
10. Serum/plasma	<input type="checkbox"/> 1	<input type="checkbox"/> 0

**Is genotype data available at your ADC?**

	Yes	No
11. APOE	<input type="checkbox"/> 1	<input type="checkbox"/> 0