MarkVCID Follow-up Paper Case Report Form Package

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MarkVCID Consortium

By the MarkVCID Clinical Data, Physiological Data & Cognitive Assessments Subcommittee (Deborah Blacker, MD, ScD, Chair) and Coordinating Center (PI Steven Greenberg, MD, PhD).

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MarkVCID Follow-up Paper CRF Package

Contents

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

DEMOGRAPHICS AND RELATED ELEMENTS: FOLLOW-UP

Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

1. Sex: ☐ Male ☐ Female

2. Subject's current marital status:

☐ Married
☐ Never married (or marriage was annulled)
☐ Widowed
☐ Living as married/domestic partner
☐ Divorced
☐ Unknown
☐ Separated

3. What is the subject's living situation?

☐ Lives alone
☐ Lives with one other person: a spouse or partner
☐ Lives with one other person: a relative, friend, or roommate
☐ Lives with caregiver who is not spouse/partner, relative, or friend
☐ Lives with a group (related or not related) in a private residence
☐ Lives in group home (e.g., assisted living, nursing home, convent)
☐ Unknown

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

4. What is the subject's level of independence?
   - ☐ Able to live independently
   - ☐ Requires some assistance with complex activities
   - ☐ Requires some assistance with basic activities
   - ☐ Completely dependent
   - ☐ Unknown

5. ZIP Code (first three digits) of subject's primary residence: ___ ___ ___ ☐ Unknown

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

MEDICAL/NEUROLOGICAL/PSYCHIATRIC: FOLLOW-UP

Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Date of Last Study Visit: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)
(To be used to ask patients about medical history **since last study visit**)

CIGARETTE SMOKING

	No	Yes	Unknown
1. Has the subject smoked **since last study visit**?	☐	☐	☐

If Yes:

1a. Average number of packs smoked per day **since last study visit**:

- ☐ 1 cigarette to less than ½ pack
- ☐ ½ pack to less than 1 pack
- ☐ 1 pack to less than 1½ packs
- ☐ 1½ packs to less than 2 packs
- ☐ 2 packs or more
- ☐ Unknown

1b. If the subject has quit smoking **since last study visit**, specify the age at which he/she last smoked (i.e., quit): __ __ __ [8-110] ☐ N/A ☐ Unknown

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

CARDIOVASCULAR DISEASE			
Since last study visit, has the patient been diagnosed with any **new** cardiovascular diseases? ☐ No ☐ Yes			
If yes:			
New Cardiovascular Disease diagnosed **since most recent study visit**	No	Yes	Not Assessed
1. Heart attack/cardiac arrest	☐	☐	☐
If yes:			
1a. More than one heart attack? ☐ No ☐ Yes ☐ Unknown			
1b. Age at most recent heart attack: __ __ ☐ Unknown			
2. Atrial fibrillation	☐	☐	☐
3. Angioplasty/ endarterectomy/ stent	☐	☐	☐
4. Cardiac bypass procedure	☐	☐	☐
5. Pacemaker and/or defibrillator	☐	☐	☐
6. Congestive heart failure	☐	☐	☐
7. Angina	☐	☐	☐
8. Heart valve replacement or repair	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

New Cardiovascular Disease diagnosed **since most recent study visit**	No	Yes	Not Assessed
9. Other cardiovascular disease (specify): (enter 'N/A' if absent) _____	☐	☐	☐
10. Other cardiovascular disease (specify): (enter 'N/A' if absent) _____	☐	☐	☐
11. Other cardiovascular disease (specify): (enter 'N/A' if absent) _____	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

CEREBROVASCULAR EVENTS			
Since last study visit, has the patient been diagnosed with a Symptomatic Stroke/Acute Vascular Event? ☐ No ☐ Yes			
New Cerebrovascular Events diagnosed since most recent study visit:			
Event	Age at Event	Type of Symptomatic Stroke/Acute Vascular Event	Temporally associated with persistent worsening of cognition?
Stroke/Acute Vascular Event 1	__ __ ☐ Unknown	☐ Ischemic ☐ Hemorrhagic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism	☐ No ☐ Yes ☐ Unknown
Stroke/Acute Vascular Event 2	__ __ ☐ Unknown	☐ Ischemic ☐ Hemorrhagic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism	☐ No ☐ Yes ☐ Unknown
Stroke/Acute Vascular Event 3	__ __ ☐ Unknown	☐ Ischemic ☐ Hemorrhagic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism	☐ No ☐ Yes ☐ Unknown
Stroke/Acute Vascular Event 4	__ __ ☐ Unknown	☐ Ischemic ☐ Hemorrhagic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism	☐ No ☐ Yes ☐ Unknown
Stroke/Acute Vascular Event 5	__ __ ☐ Unknown	☐ Ischemic ☐ Hemorrhagic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism	☐ No ☐ Yes ☐ Unknown

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

NEUROLOGIC CONDITIONS

Since last study visit, has the patient been diagnosed with any **new** neurologic conditions?
☐ No ☐ Yes

New Neurologic Conditions diagnosed since most recent study visit:

Condition	No	Yes	Not Assessed
1. Seizures	☐	☐	☐
2. Traumatic brain injury (TBI)	☐	☐	☐

If TBI yes:

2a. TBI with brief loss of consciousness (< 5 minutes)
☐ No
☐ Single
☐ Repeated/multiple
☐ Unknown

2b. TBI with extended loss of consciousness (≥ 5 minutes)
☐ No
☐ Single
☐ Repeated/multiple
☐ Unknown

2c. TBI without loss of consciousness (as might result from military detonations or sports injuries)?
☐ No
☐ Single
☐ Repeated/multiple
☐ Unknown

2d. Age at most recent TBI: __ __ ☐ Unknown

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

MEDICAL CONDITIONS			
Since last study visit, has the patient been diagnosed with any **new** medical conditions? ☐ No ☐ Yes			
New Medical Conditions diagnosed since most recent study visit:			
Condition	No	Yes	Not Assessed
1. Diabetes	☐	☐	☐
1a. If yes, which type? ☐ Type 1 ☐ Type 2 ☐ Other type (diabetes insipidus, latent autoimmune diabetes/ type 1.5, gestational diabetes) ☐ Unknown			
2. Hypertension	☐	☐	☐
2a. If yes, is hypertension treated? ☐ No ☐ Yes			
3. Hypercholesterolemia	☐	☐	☐
4. B12 deficiency	☐	☐	☐
5. Thyroid disease	☐	☐	☐
6. Arthritis	☐	☐	☐
If yes:			
6a. Type of arthritis: ☐ Rheumatoid ☐ Osteoarthritis ☐ Other (specify): _____ ☐ Unknown			
6b. Region(s) affected (check all that apply): ☐ Upper extremity ☐ Spine ☐ Lower extremity ☐ Unknown			
7. Incontinence – urinary	☐	☐	☐
8. Incontinence – bowel	☐	☐	☐
9. Sleep apnea	☐	☐	☐
10. REM sleep behavior disorder (RBD)	☐	☐	☐
11. Hyposomnia/insomnia	☐	☐	☐

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

PSYCHIATRIC CONDITIONS			
Since last study visit, has the patient been diagnosed with any **new** psychiatric conditions? ☐ No ☐ Yes			
New Psychiatric Conditions diagnosed since most recent study visit:			
Psychiatric Condition	No	Yes	Not Assessed
1. Obsessive-compulsive disorder (OCD)	☐	☐	☐
2. Developmental neuropsychiatric disorders (e.g., autism spectrum disorder [ASD], attention-deficit hyperactivity disorder [ADHD], dyslexia)	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

FAMILY HISTORY: FOLLOW-UP

Since the last visit, is any new information available concerning the patient's family history? ☐ No ☐ Yes

Corrections or new information on previously reported family history: If any previously recorded family history information has been found to be incorrect, corrections to the pertaining data should be made to that previous Family History form. Any newly obtained information (e.g., new mutation information, new reported cases of stroke/TIA or acquired cognitive impairment, new report of autopsy confirmation of diagnoses) should be indicated on this form and should not be submitted as a correction to a previously submitted Family History form.

Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

FAMILY HISTORY	No	Yes	Unknown
1. STROKE/TIA: Is there a family history in a first degree relative of symptomatic stroke or TIA with clear ischemic mechanism?	☐	☐	☐
If yes:			
1a. Any cases with onset before age 55?	☐	☐	☐
1b. Is there a pattern suggestive of an autosomal dominant family history?	☐	☐	☐
2. ACQUIRED COGNITIVE IMPAIRMENT: Is there a family history in a first degree relative of cognitive impairment or dementia or Alzheimer's disease?	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

	No	Yes	Unknown
If yes:			
2a. Any report of a case in the family with autopsy confirmation of Alzheimer's disease?	☐	☐	☐
2b. Any report of cases with autopsy confirmation of another cause of dementia?	☐	☐	☐
2c. Any cases with onset before age 65?	☐	☐	☐
2d. Is there a pattern suggestive of an autosomal dominant family history?	☐	☐	☐

3. **If yes** to EITHER autosomal dominant questions above (1b, 2d), complete the following:

3a. Is there a known mutation?

☐ No ☐ Yes

3b. If yes, please indicate which one:

☐ PSEN1

☐ APP

☐ PSEN2

☐ CADASIL

☐ Other, specify gene if known: _____

Specify mutation if known: _____

3c. Does this individual carry the mutation?

☐ No ☐ Yes ☐ Unknown

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

GENERAL PHYSICAL MEASURES

Were General Physical Measures performed?

☐ No ☐ Yes

If No, please provide the primary reason:

☐ Physical problem ☐ Verbal refusal

☐ Cognitive/behavior problem ☐ Other problem (specify): _____

_____

Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

VITAL SIGNS

Measure seated at rest. Take 3 consecutive BP readings. Average will be calculated in EDC.

1. Blood Pressure Measurement 1: __ __ __ / __ __ __ mmHg ☐ Not Done

   Blood Pressure Measurement 2: __ __ __ / __ __ __ mmHg ☐ Not Done

   Blood Pressure Measurement 3: __ __ __ / __ __ __ mmHg ☐ Not Done

2. Pulse: __ __ __ beats/minute ☐ Not Done
3. Height: __ __ __ . __ ☐ cm ☐ in ☐ Not Done
4. Weight: __ __ __ . __ ☐ kg ☐ lb ☐ Not Done

ADDITIONAL PHYSICAL OBSERVATIONS	No	Yes	Unknown
1. With or without corrective lenses, is the subject's vision functionally normal?	☐	☐	☐
2. With or without a hearing aid(s), is the subject's hearing functionally normal?	☐	☐	☐

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

SHORT PHYSICAL PERFORMANCE BATTERY	
KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes: 95 = Physical problem 96 = Cognitive/behavior problem 97 = Other problem 98 = Verbal refusal	
1. Balance Test Score: *Side-by-side, semi-tandem, tandem*:	___ ___ [0-4, 95-98]
2. Gait Speed Test Score:	___ ___ [0-4, 95-98]
3. Chair Stand Test Score:	___ ___ [0-4, 95-98]

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

NEUROLOGICAL EXAM

Was the Neurological Exam performed?

☐ No ☐ Yes

If No, please provide the primary reason:

☐ Physical problem ☐ Verbal refusal

☐ Cognitive/behavior problem ☐ Other problem (specify): _____

_____

Date of Collection: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

PARKINSONIAN FEATURES			
Were Parkinsonian signs present? ☐ No ☐ Yes			
Parkinsonian Signs: **LEFT**	No	Yes	Not Assessed
1. Resting tremor – arm	☐	☐	☐
2. Slowing of fine motor movements	☐	☐	☐
3. Rigidity - arm	☐	☐	☐
Parkinsonian Signs: **RIGHT**	No	Yes	Not Assessed
4. Resting tremor – arm	☐	☐	☐
5. Slowing of fine motor movements	☐	☐	☐
6. Rigidity - arm	☐	☐	☐
Parkinsonian Signs	No	Yes	Not Assessed
7. Bradykinesia	☐	☐	☐
8. Parkinsonian gait disorder	☐	☐	☐
9. Postural instability	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

CEREBROVASCULAR FEATURES			
Were neurological signs considered by examiner to be most likely consistent with cerebrovascular disease present? ☐ No ☐ Yes			
Findings consistent with stroke / cerebrovascular disease	No	Yes	Not Assessed
1. Cortical cognitive deficit (e.g., aphasia, apraxia, neglect)	☐	☐	☐
Findings consistent with stroke / cerebrovascular disease: **LEFT SIDE OF BODY**	No	Yes	Not Assessed
2. Lateralized motor weakness	☐	☐	☐
3. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	☐	☐	☐
4. Cortical visual field loss	☐	☐	☐
5. Somatosensory loss	☐	☐	☐
Findings consistent with stroke / cerebrovascular disease: **RIGHT SIDE OF BODY**	No	Yes	Not Assessed
6. Lateralized motor weakness	☐	☐	☐
7. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	☐	☐	☐
8. Cortical visual field loss	☐	☐	☐
9. Somatosensory loss	☐	☐	☐

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

OTHER FINDINGS	No	Yes	Not Assessed
1. Patient demonstrates spontaneous, disproportionate or involuntary crying or laughing on examination	☐	☐	☐
2. Is magnetic gait apraxia present?	☐	☐	☐
3. Higher cortical visual problem suggesting posterior cortical atrophy (e.g., prosopagnosia, simultagnosia, Balint's syndrome) or apraxia of gaze	☐	☐	☐
4. Findings suggestive of progressive supranuclear palsy (PSP), corticobasal syndrome, or other related disorders	☐	☐	☐
5. Findings suggesting ALS (e.g., muscle wasting, fasciculations, upper motor neuron and/or lower motor neuron signs)	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

COGNITIVE DIAGNOSIS

Date of Evaluation: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

SYNDROMIC DIAGNOSIS

☐ Normal Cognition ☐ Impaired, Not MCI

☐ MCI ☐ Dementia

Age of Onset: __ __ ☐ Unknown

PRIMARY ETIOLOGICAL DIAGNOSES	Present		Primary	Contributing	Non-contributing
	No	Yes			
1. Alzheimer's disease	☐	☐	☐	☐	☐
2. Lewy body disease	☐	☐	☐	☐	☐
2a. Parkinson's disease	☐	☐			
3. Vascular brain injury (based on clinical or imaging evidence)	☐	☐	☐	☐	☐
3a. Peri-Ventricular Fazekas Extent Grade	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ Unknown/ N/A				
3b. Deep Fazekas Extent Grade	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ Unknown/ N/A				
3c. Deep Fazekas Lesion Count Grade	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ Unknown/ N/A				
	Present		Primary	Contributing	Non-contributing
	No	Yes			
4. Traumatic brain injury	☐	☐	☐	☐	☐
If Present: 4a. If present, does the subject have symptoms consistent with chronic traumatic encephalopathy?	☐ No ☐ Yes ☐ Unknown				

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

	Present		Primary	Contributing	Non-contributing
	No	Yes			
5. Depression	☐	☐	☐	☐	☐
If Present: 5a. ☐ Untreated ☐ Treated with medication and/or counseling					
	Present		Primary	Contributing	Non-contributing
	No	Yes			
6. Cognitive impairment due to alcohol abuse	☐	☐	☐	☐	☐
If Present: 6a. Current alcohol abuse	☐ No	☐ Yes	☐ Unknown		

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

RELATED ETIOLOGICAL DIAGNOSES	Present	Primary	Contributing	Non-contributing
7. Multiple system atrophy	☐	☐	☐	☐
8. Frontotemporal lobar degeneration	☐	☐	☐	☐
9. Essential tremor	☐	☐	☐	☐
10. Down syndrome	☐	☐	☐	☐
11. Huntington's disease	☐	☐	☐	☐
12. Prion disease (CJD, other)	☐	☐	☐	☐
13. Hydrocephalus	☐	☐	☐	☐
14. Epilepsy	☐	☐	☐	☐
15. CNS neoplasm	☐	☐	☐	☐
If present: 15a. ☐ Benign ☐ Malignant				
16. Human immunodeficiency virus (HIV)	☐	☐	☐	☐
17. Bipolar disorder	☐	☐	☐	☐
18. Schizophrenia or other psychosis	☐	☐	☐	☐
19. Anxiety disorder	☐	☐	☐	☐
20. Delirium	☐	☐	☐	☐
21. Post-traumatic stress disorder (PTSD)	☐	☐	☐	☐

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

	Present	Primary	Contributing	Non-contributing
22. Other psychiatric disease (specify): _____ _____	☐	☐	☐	☐
23. Cognitive impairment due to:				
23a. Other neurologic, genetic, or infectious conditions not listed above (specify): _____ _____ _____	☐	☐	☐	☐
23b. Other substance abuse	☐	☐	☐	☐
23c. Systemic disease/medical illness	☐	☐	☐	☐
23d. Medications	☐	☐	☐	☐
23e. Cognitive impairment NOS: _____ _____	☐	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

MoCA (MONTREAL COGNITIVE ASSESSMENT)

Was any part of the MoCA administered?

☐ No ☐ Yes

If No, please provide the primary reason: ☐ Physical problem ☐ Verbal refusal

☐ Cognitive/behavior problem ☐ Other problem (specify): _____

_____

Date of Examination: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Language of test administration:

☐ English

☐ Spanish

☐ Other (specify): _____

KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:

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

1. Visuospatial/ executive — Trails:	__ __ [0-1, 95-98]
2. Visuospatial/ executive — Cube:	__ __ [0-1, 95-98]
3. Visuospatial/ executive — Clock contour:	__ __ [0-1, 95-98]
4. Visuospatial/ executive — Clock numbers:	__ __ [0-1, 95-98]
5. Visuospatial/ executive — Clock hands:	__ __ [0-1, 95-98]
6. Language — Naming:	__ __ [0-3, 95-98]
7. Memory — Registration (two trials):	__ __ [0-10, 95-98]

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

8. Attention — Digits:	___ ___ [0-2, 95-98]
9. Attention — Letter A:	___ ___ [0-1, 95-98]
10. Attention — Serial 7s:	___ ___ [0-3, 95-98]
11. Language — Repetition:	___ ___ [0-2, 95-98]
12. Language — Fluency:	___ ___ [0-1, 95-98]
13. Abstraction:	___ ___ [0-2, 95-98]
14. Delayed recall — No cue: *(if not completed, enter reason code and skip to question 17)*	___ ___ [0-5, 95-98]
15. Delayed recall — Category cue:	___ ___ [0-5, 95-98]
16. Delayed recall — Recognition:	___ ___ [0-5, 95-98]
17. Orientation — Date:	___ ___ [0-1, 95-98]
18. Orientation — Month:	___ ___ [0-1, 95-98]
19. Orientation — Year:	___ ___ [0-1, 95-98]
20. Orientation — Day:	___ ___ [0-1, 95-98]
21. Orientation — Place:	___ ___ [0-1, 95-98]
22. Orientation — City:	___ ___ [0-1, 95-98]

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

NEUROPSYCHOLOGICAL TESTING BATTERY

Was any part of the Neuropsychological Testing Battery administered?

☐ No ☐ Yes

If No, please provide the primary reason: ☐ Physical problem ☐ Verbal refusal

☐ Cognitive/behavior problem ☐ Other problem (specify): _____

_____

Date of Examination: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

Language of test administration:

☐ English

☐ Spanish

☐ Other (specify): _____

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:

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

1. Craft Story 21 Recall (Immediate):
   a) If test not completed, enter reason code and skip to question 2a: ___ ___ [95-98]
   b) Total story units recalled, verbatim scoring: ___ ___ [0-44]
   c) Total story units recalled, paraphrase scoring: ___ ___ [0-25]

2. Craft Story 21 Recall (Delayed):
   a) If test not completed, enter reason code and skip to question 3a: ___ ___ [95-98]
   b) Total story units recalled, verbatim scoring: ___ ___ [0-44]
   c) Total story units recalled, paraphrase scoring: ___ ___ [0-25]
   d) Delay time (minutes): ☐ Unknown ___ ___ [0-85]
   e) Cue ("boy") needed: ☐ No ☐ Yes

3. Number Span Test — Forward:
   a) If test not completed, enter reason code and skip to question 4a: ___ ___ [95-98]
   b) Number of correct trials: ___ ___ [0-14]
   c) Longest span forward: ___ ___ [0, 3-9]

4. Number Span Test — Backward:
   a) If test not completed, enter reason code and skip to question 5a: ___ ___ [95-98]
   b) Number of correct trials: ___ ___ [0-14]
   c) Longest span backward: ___ ___ [0, 2-8]

5. Category Fluency – Animals:
   a) If test not completed, enter reason code and skip to question 6a: ___ ___ [95-98]
   b) Total number of animals named in 60 seconds: ___ ___ [0-77]

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

6. Verbal Fluency – Phonemic Tests (words beginning with F):
   a) If test not completed, enter reason code and skip to question 7a: ___ ___ [95-98]
   b) Number of correct F-words generated in 1 minute: ___ ___ [0-40]
   c) Number of F-words repeated in 1 minute: ___ ___ [0-15]
   d) Number of non-F-words and rule violation errors in 1 minute: ___ ___ [0-15]

7. Trail Making Test A:
   a) If test not completed, enter reason code and skip to question 8a: ___ ___ [95-98]
   b) Total number of seconds to complete (if not finished by 150 seconds, enter 150)
      ___ ___ ___ [0-150]
      i. Number of commission errors: ___ ___ [0-40]
      ii. Number of correct lines: ___ ___ [0-24]

8. Trail Making Test B:
   a) If test not completed, enter reason code and skip to question 9a: ___ ___ [95-98]
   b) Total number of seconds to complete (if not finished by 300 seconds, enter 300):
      ___ ___ ___ [0-300]
      i. Number of commission errors: ___ ___ [0-40]
      ii. Number of correct lines: ___ ___ [0-24]

9. Multilingual Naming Test (MINT):
   a) If test not completed, enter reason code and skip to question 10a:___ ___ [95-98]
   b) Total score (9c+ 9e): ___ ___ [0-32]
   c) Total correct without any cues (Uncued): ___ ___ [0-32]
   d) Semantic cues – Number given: ___ ___ [0-32]
   e) Semantic cues – Number correct with cue: ☐ N/A ___ ___ [0-32]
   f) Phonemic cues – Number given: ___ ___ [0-32]
   g) Phonemic cues – Number correct with cue: ☐ N/A ___ ___ [0-32]

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

10. Word list learning with immediate/delay/recognition:
    a) Name of test: ☐ HVLT ☐ CVLT
    ☐ CVLT-SF ☐ SEVLT [Spanish]
    ☐ Other (specify): _____
    b) Total number of words on list: __ __
    c) If test not completed, please select reason code: __ __ [95-98]
    d) Learning Trial 1: __ __
    e) Learning Trial 2: __ __
    f) Learning Trial 3: __ __
    g) Learning Trial 4: ☐ N/A __ __
    h) Learning Trial 5: ☐ N/A __ __
    i) Delay duration (if multiple options choose longest): __ __
    j) Delayed recall (if multiple delay options, choose longest): __ __
    k) Recognition hits: __ __
    l) Recognition false positives: __ __

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

CDR (CLINICAL DEMENTIA RATING)

Was the CDR administered?

☐ No ☐ Yes

If No, please provide the primary reason: ☐ Physical problem ☐ Verbal refusal

☐ Cognitive/behavior problem ☐ Other problem (specify): _____

_____

Date of Evaluation: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Section 1: Standard CDR

Please enter score below:	IMPAIRMENT				
	None – 0	Questionable – 0.5	Mild – 1	Moderate – 2	Severe – 3
1. Memory __ . __	No memory loss, or slight inconsistent forgetfulness	Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness	Moderate memory loss, more marked for recent events; defect interferes with everyday activities	Severe memory loss; only highly learned material retained; new material rapidly lost	Severe memory loss; only fragments remain
2. Orientation __ . __	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere	Severe difficulty with time relationships; usually disoriented to time, often to place	Oriented to person only
3. Judgment and problem solving __ . __	Solves everyday problems, handles business and 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

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

4. Community affairs ___ . ___	Independent function at usual level in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently at these activities, although may still be engaged in some; appears normal to casual inspection	No pretense of independent function outside the home; appears well enough to be taken to functions outside the family home	No pretense of independent function outside the home; appears too ill to be taken to functions outside the family home
5. Home and hobbies ___ . ___	Life at home, hobbies, and intellectual interests well maintained	Life at home, hobbies, and intellectual interests slightly impaired	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned	Only simple chores preserved; very restricted interests, poorly maintained	No significant function in the home
6. Personal care ___ . 0	Fully capable of self-care (= 0).		Needs prompting	Requires assistance in dressing, hygiene, keeping of personal effects	Requires much help with personal care; frequent incontinence
8. ___ ___ STANDARD GLOBAL CDR					

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Section 2: Supplemental CDR					
Please enter score below:	IMPAIRMENT				
	None – 0	Questionable – 0.5	Mild – 1	Moderate – 2	Severe – 3
1. Behavior, comportment, and personality __ . __	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
2. Language __ . __	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

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

GDS (GERIATRIC DEPRESSION SCALE)

Was the GDS administered?

☐ No ☐ Yes

If No, please provide the primary reason: ☐ Physical problem ☐ Verbal refusal

☐ Cognitive/behavior problem ☐ Other problem (specify): _____

_____

Date of Evaluation: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

	Yes	No	Did not answer
1. Are you basically satisfied with your life?	☐	☐	☐
2. Have you dropped many of your activities and interests?	☐	☐	☐
3. Do you feel that your life is empty?	☐	☐	☐
4. Do you often get bored?	☐	☐	☐
5. Are you in good spirits most of the time?	☐	☐	☐
6. Are you afraid that something bad is going to happen to you?	☐	☐	☐
7. Do you feel happy most of the time?	☐	☐	☐
8. Do you often feel helpless?	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials: ____ ____ ____**
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials: ____ ____ ____**
Study Visit:	

	Yes	No	Did not answer
9. Do you prefer to stay at home, rather than going out and doing new things?	☐	☐	☐
10. Do you feel you have more problems with memory than most people?	☐	☐	☐
11. Do you think it is wonderful to be alive?	☐	☐	☐
12. Do you feel pretty worthless the way you are now?	☐	☐	☐
13. Do you feel full of energy?	☐	☐	☐
14. Do you feel that your situation is hopeless?	☐	☐	☐
15. Do you think that most people are better off than you are?	☐	☐	☐

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

LABORATORY TESTS

Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

PHYSIOLOGIC MEASURES
If fasting conditions are unknown, mark "not fasting".
*All tests denoted with * are required. Cholesterol related labs, blood sugar, and homocysteine should be collected under fasting conditions when possible.*

Measure	Fasting	Result	
1. HS-CRP	N/A	__ __ __ mg/L	☐ Not Done
2. HbA1c	N/A	__ __ __ mmol/mol	☐ Not Done
3. Blood Sugar*	☐ Fasting >8 hours ☐ Not fasting	__ __ __ mmol/L	☐ Not Done
4. Serum cholesterol*	☐ Fasting >8 hours ☐ Not fasting	__ __ __ mg/dL	☐ Not Done
5. HDL cholesterol*	☐ Fasting >8 hours ☐ Not fasting	__ __ __ mg/dL	☐ Not Done
6. LDL cholesterol*	☐ Fasting >8 hours ☐ Not fasting	__ __ __ mg/dL	☐ Not Done
7. Triglycerides*	☐ Fasting >8 hours ☐ Not fasting	__ __ __ mg/dL	☐ Not Done
8. Homocysteine	☐ Fasting >8 hours ☐ Not fasting	__ __ __ mg/dL	☐ Not Done

GENETICS

Have any genetic tests been performed? If this is a follow up visit, only answer for any new tests performed. ☐ No ☐ Yes

If yes:

APOE genotype: ☐ E2/E2 ☐ E2/E3 ☐ E2/E4 ☐ E3/E3 ☐ E3/E4 ☐ E4/E4 ☐ Not Done

Has a GWAS been completed? ☐ No ☐ Yes

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

SAMPLE COLLECTION: CSF COLLECTION
Status: ☐ Collected ☐ Not Collected
If not collected, reason not collected: _____ _____
Date CSF Samples Collected: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)
Time since last meal: ___ ___ hours
Time Collected: ___ ___ : ___ ___ (24 hour clock)
Collector's Initials: ___ ___ ___ (enter dash if no middle name)
Pre-Centrifugation sample: Appearance: ☐ Clear ☐ Cloudy Color: ☐ Pink ☐ Other (specify): _____ _____
Number of 0.25 mL aliquots: ___ ___

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Were there any deviations? ☐ No ☐ Yes

If YES, indicate deviations below (select all that apply):

☐ Sample not placed on dry ice or in -80º C freezer immediately after aliquoting

If selected, please select one of the following:

☐ Placed on dry ice or in freezer within 30 minutes of aliquoting
☐ Placed on dry ice or in freezer 30-60 minutes after aliquoting
☐ Placed on dry ice or in freezer 60+ minutes after aliquoting

☐ The participant was NOT fasting for a minimum of 6 hours prior to collection

☐ Other deviation (specify): _____

_____

_____

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

SAMPLE COLLECTION: PLASMA COLLECTION
Status: ☐ Collected ☐ Not Collected
If not collected, reason not collected: _____ _____
Date Plasma Samples Collected: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)
Time since last meal: ___ ___ (hours)
Time Collected: ___ ___ : ___ ___ (24 hour clock)
Collector's Initials: ___ ___ ___ (enter dash if no middle name)
Number of 0.25 mL plasma aliquots: ___ ___
Number of 1 mL packed cell aliquots for DNA: ___ ___
Temperature of Centrifugation: ___ ___ °C
Did plasma remain pink after centrifugation, indicating hemolysis? ☐ No ☐ Yes
Storage temperature: ___ ___ °C

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Were there any deviations? ☐ No ☐ Yes

If YES, indicate deviations below (select all that apply):

☐ Sample tube was not inverted 5-10 times

☐ Sample not spun within 2 hours of collection
If selected, please select one of the following:
- ☐ Spun 2-3 hours after collection
- ☐ Spun 3-4 hours after collection
- ☐ Spun 4+ hours after collection

☐ Sample not spun at 2000g
If selected, please select one of the following:
- ☐ Spun slower than 2000g
- ☐ Spun faster than 2000g

☐ Sample not spun for 10 minutes
If selected, please select one of the following:
- ☐ Spun <10 minutes
- ☐ Spun >10 minutes

☐ Sample not placed on dry ice or in -80º C freezer immediately after aliquoting
If selected, please select one of the following:
- ☐ Placed on dry ice or in freezer within 30 minutes of aliquoting
- ☐ Placed on dry ice or in freezer 30-60 minutes after aliquoting
- ☐ Placed on dry ice or in freezer 60+ minutes after aliquoting

☐ Other deviation (specify): _____

_____

_____

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

SAMPLE COLLECTION: SERUM COLLECTION
Status: ☐ Collected ☐ Not Collected
If not collected, reason not collected: _____ _____
Date Serum Samples Collected: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)
Time since last meal: ___ ___ (hours)
Time Collected: ___ ___ : ___ ___ (24 hour clock)
Collector's Initials: ___ ___ ___ (enter dash if no middle name)
Number of 0.25 mL aliquots: ___ ___
Temperature of Centrifugation: ___ ___ °C
Did serum remain pink after centrifugation, indicating hemolysis? ☐ No ☐ Yes
Storage temperature: ___ ___ °C

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Were there any deviations? ☐ No ☐ Yes

If YES, indicate deviations below (select all that apply):

☐ After collection, sample not allowed to sit in vertical position for 30-60 minutes (select all that apply):
- ☐ Sample not kept vertical
- ☐ Sample did not sit for 30-60 minutes after collection
  - If selected, please select one of the following:
    - ☐ Sample sat <30 minutes
    - ☐ Sample sat >60 minutes

☐ Sample not spun at 2000g
- If selected, please select one of the following:
  - ☐ Spun slower than 2000g
  - ☐ Spun faster than 2000g

☐ Sample not spun for 10 minutes
- If selected, please select one of the following:
  - ☐ Spun <10 minutes
  - ☐ Spun >10 minutes

☐ Sample not placed on dry ice or in -80º C freezer immediately after aliquoting
- If selected, please select one of the following:
  - ☐ Placed on dry ice or in freezer within 30 minutes of aliquoting
  - ☐ Placed on dry ice or in freezer 30-60 minutes after aliquoting
  - ☐ Placed on dry ice or in freezer 60+ minutes after aliquoting

☐ Other deviation (specify): _____

_____

_____

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

SAMPLE COLLECTION: PLATELET POOR PLASMA (PPP) COLLECTION
Status: ☐ Collected ☐ Not Collected
If not collected, reason not collected: _____ _____
Date PPP Samples Collected: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)
Time Collected: ___ ___ : ___ ___ (24 hour clock)
Collector's Initials: ___ ___ ___ (enter dash if no middle name)
Time since last meal: ___ ___ hours
Number of 0.25 mL aliquots: ___ ___
Did plasma remain pink after centrifugation, indicating hemolysis? ☐ No ☐ Yes
Storage temperature: ___ ___ °C

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Were there any deviations? ☐ No ☐ Yes

If YES, indicate deviations below (select all that apply):

☐ Sample tube was not inverted 5-10 times

☐ Sample not spun within 2 hours of collection
If selected, please complete the following:
Spun ___ ___ hours after collection (round to nearest hour)

☐ Sample not spun at 500g (first centrifugation step)
If selected, please complete the following:
Speed sample spun at: ___ ___ g

☐ Sample not spun for 20 minutes (first centrifugation step)
If selected, please complete the following:
Duration of spin: ___ ___ min

☐ Sample not spun at 20C (first centrifugation step)
If selected, please complete the following:
Temperature of spin: ___ ___ C

☐ Sample not mixed at a 1:1 ratio after first centrifugation step
If selected, please complete the following:
Volume of supernatant (platelet rich plasma): ___ ___ mL
Volume of DBS with additives: ___ ___ mL

☐ Sample not spun at 2,200g (second centrifugation step)
If selected, please complete the following:
Speed sample spun at: ___ ___ g

☐ Sample not spun for 20 minutes (second centrifugation step)
If selected, please complete the following:
Duration of spin: ___ ___ min

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Deviations (continued):

☐ Sample not spun at 20C (second centrifugation step)
If selected, please complete the following:
Temperature of spin: ___ ___ C

☐ Sample not placed on dry ice or in -80º C freezer immediately after aliquoting
If selected, please select one of the following:
☐ Placed on dry ice or in freezer within 30 minutes of aliquoting
☐ Placed on dry ice or in freezer 30-60 minutes after aliquoting
☐ Placed on dry ice or in freezer 60+ minutes after aliquoting

☐ Other deviation (specify): _____

_____

_____

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

IMAGING		
Was an MRI performed at this visit?	☐ No	☐ Yes
If No, please provide reason:	☐ Claustrophobia ☐ Other reason: _____ _____	
Date of Imaging: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)		

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

OCTA SCREENING WORKSHEET

Date of OCTA Screening: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Exclusion Criteria
*If the subject answers "yes" to any questions under #1-4, please **DO NOT** perform OCTA testing on the subject.*

Criterion	No	Yes	N/A
1. Have you ever been diagnosed with any of the following eye diseases?			
1.1. Glaucoma	☐	☐	
1.2. Diabetic Retinopathy	☐	☐	
1.3. Advanced Dry Age-Related Macular Degeneration	☐	☐	
1.4. Advanced Wet Age-Related Macular Degeneration	☐	☐	
2. Have you ever had any of the following procedures done?			
2.1. Laser Surgery on either eye for any reason *(excluding cosmetic or refractive procedures such as LASIK or cataract surgery)*	☐	☐	
2.2. Injections into or around either eye *(excluding cosmetic procedures)*	☐	☐	

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Criterion	**No**	**Yes**	**N/A**
3. If you have had your eyes dilated for an examination in the past,			
3.1. Did you have a problem or allergy (excluding blurry vision)? (*Mark not applicable if patient has never had their eyes dilated for an eye examination)*	☐	☐	☐
3.2. Were you told not to get dilated again? (*Mark not applicable if patient has never had their eyes dilated for an eye examination)*	☐	☐	☐
4. Do you take any prescription eye drops (excluding artificial tears)?	☐	☐	
OCTA Enrollment			
☐ Subject cannot undergo OCTA testing because of exclusion criteria ☐ Subject is enrolled in OCTA testing and agrees to dilation of right eye. If the subject does not agree to dilation, they are not eligible for enrollment in the study			

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ ____ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

OCTA: INITIAL OR ANNUAL FOLLOW-UP

Date of OCTA Scans: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Right Eye Dilation

☐ Subject's right eye is topically anesthetized with 1-2 drops Proparacaine 0.5%

☐ Subject's right eye is dilated with 1-2 drops each of:

- ☐ Tropicamide 1%
- ☐ Phenylephrine 2.5%
- ☐ Other (specify): _____

(Note: If subject does not appear well dilated after 10 minutes it is reasonable to administer another drop of each dilating drop)

OCTA Scans

Scan Number	Signal Strength
Right Eye Angiography 3x3 mm Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Scan Number	Signal Strength
Left Eye Angiography 3x3 mm Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ___ ___/ ___ ___/ ___ __ ___ ___	**Evaluator Initials:** ____ ____ ____
Study Visit:	

1. Has the subject seen an eye doctor in the past 5 years?	☐ No ☐ Yes ☐ Unknown
1a. *If yes,* has the subject released the medical records from this time period?	☐ No ☐ Yes ☐ Unknown
2. Does the subject wear glasses or contacts?	☐ No ☐ Yes ☐ Unknown
2a. *If yes,* are they worn to improve reading vision?	☐ No ☐ Yes ☐ Unknown
2b. *If yes,* are they worn to improve distance vision?	☐ No ☐ Yes ☐ Unknown
3. Has the subject ever had any of the following?	
3a. Cataract Surgery on Right Eye	☐ No ☐ Yes ☐ Unknown
3b. Cataract Surgery on Left Eye	☐ No ☐ Yes ☐ Unknown
Same-Day Retest	
Was this the initial OCTA scan?	☐ No ☐ Yes
If this was the initial OCTA scan, was a retest completed on the same day?	☐ No ☐ Yes

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

OCTA: TEST/RETEST – SAME DAY

Date of OCTA Scans: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Right Eye Dilation

☐ Subject's right eye is topically anesthetized with 1-2 drops Proparacaine 0.5%

☐ Subject's right eye is dilated with 1-2 drops each of:

- ☐ Tropicamide 1%
- ☐ Phenylephrine 2.5%
- ☐ Other (specify): _____

(Note: If subject does not appear well dilated after 10 minutes it is reasonable to administer another drop of each dilating drop)

OCTA Scans

Scan Number	Signal Strength
Right Eye Angiography 3x3 mm Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done

MarkVCID Follow-up Paper CRF Package

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Scan Number	Signal Strength
Left Eye Angiography 3x3 mm Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

OCTA: TEST/RETEST – WITHIN 14 DAYS

Date of OCTA Scans: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Right Eye Dilation

☐ Subject's right eye is topically anesthetized with 1-2 drops Proparacaine 0.5%

☐ Subject's right eye is dilated with 1-2 drops each of:

- ☐ Tropicamide 1%
- ☐ Phenylephrine 2.5%
- ☐ Other (specify): _____

(Note: If subject does not appear well dilated after 10 minutes it is reasonable to administer another drop of each dilating drop)

OCTA Scans

Scan Number	Signal Strength
Right Eye Angiography 3x3 mm Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Angiography 3x3 mm Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Right Eye Optic Disc Cube 200x200 Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done

MarkVCID Follow-up Paper CRF Package

Patient ID: __ __ __ __ __ __ __ __ __ __	**Patient Initials:** ____ ____ ____
Visit Date: ____ ____/ ____ ____/ ____ __ ____ ____	**Evaluator Initials:** ____ ____ ____
Study Visit:	

Scan Number	Signal Strength
Left Eye Angiography 3x3 mm Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Angiography 3x3 mm Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 1	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 2	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 3	☐ 8 ☐ 9 ☐ 10 ☐ Not Done
Left Eye Optic Disc Cube 200x200 Scan 4	☐ 8 ☐ 9 ☐ 10 ☐ Not Done