



National Institutes of Health

National Institute of Neurological Disorders and Stroke
National Institute on Aging

MarkVCID Follow-up Paper Case Report Form Package

Version 6.0, November 2, 2020
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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The MarkVCID Consortium is funded by the National Institutes of Health through the National Institute of Neurological Disorders and Stroke and National Institute on Aging (Cooperative Agreement U24NS100591).

MarkVCID Follow-up Paper CRF Package

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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:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Married | <input type="checkbox"/> Never married (or marriage was annulled) |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Living as married/domestic partner |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> 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

MarkVCID Follow-up Paper CRF Package

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

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>MEDICAL/NEUROLOGICAL/PSYCHIATRIC: FOLLOW-UP</u>			
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 ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes:			
1a. Average number of packs smoked per day since last study visit : <input type="checkbox"/> 1 cigarette to less than ½ pack <input type="checkbox"/> ½ pack to less than 1 pack <input type="checkbox"/> 1 pack to less than 1½ packs <input type="checkbox"/> 1½ packs to less than 2 packs <input type="checkbox"/> 2 packs or more <input type="checkbox"/> 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] <input type="checkbox"/> N/A <input type="checkbox"/> Unknown			

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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? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes:			
New Cardiovascular Disease diagnosed since most recent study visit	No	Yes	Not Assessed
1. Heart attack/cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes:			
1a. More than one heart attack? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			
1b. Age at most recent heart attack: ____ <input type="checkbox"/> Unknown			
2. Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Angioplasty/endarterectomy/stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cardiac bypass procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pacemaker and/or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Heart valve replacement or repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other cardiovascular disease (specify): (enter 'N/A' if absent) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Other cardiovascular disease (specify): (enter 'N/A' if absent) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID Follow-up Paper CRF Package

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? <input type="checkbox"/> No <input type="checkbox"/> 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	____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 2	____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 3	____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 4	____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stroke/Acute Vascular Event 5	____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

MarkVCID Follow-up Paper CRF Package

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? <input type="checkbox"/> No <input type="checkbox"/> Yes			
New Neurologic Conditions diagnosed since most recent study visit:			
Condition	No	Yes	Not Assessed
1. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Traumatic brain injury (TBI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If TBI yes:			
2a. TBI with brief loss of consciousness (< 5 minutes) <input type="checkbox"/> No <input type="checkbox"/> Single <input type="checkbox"/> Repeated/multiple <input type="checkbox"/> Unknown			
2b. TBI with extended loss of consciousness (≥ 5 minutes) <input type="checkbox"/> No <input type="checkbox"/> Single <input type="checkbox"/> Repeated/multiple <input type="checkbox"/> Unknown			
2c. TBI without loss of consciousness (as might result from military detonations or sports injuries)? <input type="checkbox"/> No <input type="checkbox"/> Single <input type="checkbox"/> Repeated/multiple <input type="checkbox"/> Unknown			
2d. Age at most recent TBI: ____ <input type="checkbox"/> Unknown			

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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?			
<input type="checkbox"/> No <input type="checkbox"/> Yes			
New Medical Conditions diagnosed since most recent study visit:			
Condition	No	Yes	Not Assessed
1. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1a. If yes, which type?			
<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other type (diabetes insipidus, latent autoimmune diabetes/ type 1.5, gestational diabetes) <input type="checkbox"/> Unknown			
2. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2a. If yes, is hypertension treated? <input type="checkbox"/> No <input type="checkbox"/> Yes			
3. Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. B12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes:			
6a. Type of arthritis:			
<input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown			
6b. Region(s) affected (check all that apply):			
<input type="checkbox"/> Upper extremity <input type="checkbox"/> Spine <input type="checkbox"/> Lower extremity <input type="checkbox"/> Unknown			
7. Incontinence - urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Incontinence - bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. REM sleep behavior disorder (RBD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Hyposomnia/insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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? <input type="checkbox"/> No <input type="checkbox"/> Yes			
New Psychiatric Conditions diagnosed since most recent study visit:			
Psychiatric Condition	No	Yes	Not Assessed
1. Obsessive-compulsive disorder (OCD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Developmental neuropsychiatric disorders (e.g., autism spectrum disorder [ASD], attention-deficit hyperactivity disorder [ADHD], dyslexia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>FAMILY HISTORY: FOLLOW-UP</u>			
Since the last visit, is any new information available concerning the patient's family history? <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes:			
1a. Any cases with onset before age 55?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1b. Is there a pattern suggestive of an autosomal dominant family history?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. ACQUIRED COGNITIVE IMPAIRMENT: Is there a family history in a first degree relative of cognitive impairment or dementia or Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2b. Any report of cases with autopsy confirmation of another cause of dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2c. Any cases with onset before age 65?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2d. Is there a pattern suggestive of an autosomal dominant family history?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If yes to EITHER autosomal dominant questions above (1b, 2d), complete the following:			
3a. Is there a known mutation? <input type="checkbox"/> No <input type="checkbox"/> Yes			
3b. If yes, please indicate which one: <input type="checkbox"/> PSEN1 <input type="checkbox"/> APP <input type="checkbox"/> PSEN2 <input type="checkbox"/> CADASIL <input type="checkbox"/> Other, specify gene if known: _____ Specify mutation if known: _____			
3c. Does this individual carry the mutation? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			

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Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>GENERAL PHYSICAL MEASURES</u>			
Were General Physical Measures performed? <input type="checkbox"/> No <input type="checkbox"/> Yes If No, please provide the primary reason: <input type="checkbox"/> Physical problem <input type="checkbox"/> Verbal refusal <input type="checkbox"/> Cognitive/behavior problem <input type="checkbox"/> Other problem (specify): _____			
Date of Collection: ____ / ____ / _____ (MM/DD/YYYY)			
VITAL SIGNS			
<i>Measure seated at rest. Take 3 consecutive BP readings. Average will be calculated in EDC.</i>			
1. Blood Pressure Measurement 1: _____ / _____ mmHg	<input type="checkbox"/> Not Done		
Blood Pressure Measurement 2: _____ / _____ mmHg	<input type="checkbox"/> Not Done		
Blood Pressure Measurement 3: _____ / _____ mmHg	<input type="checkbox"/> Not Done		
2. Pulse: _____ beats/minute	<input type="checkbox"/> Not Done		
3. Height: _____ . ____ <input type="checkbox"/> cm <input type="checkbox"/> in	<input type="checkbox"/> Not Done		
4. Weight: _____ . ____ <input type="checkbox"/> kg <input type="checkbox"/> lb	<input type="checkbox"/> Not Done		
ADDITIONAL PHYSICAL OBSERVATIONS	No	Yes	Unknown
1. With or without corrective lenses, is the subject's vision functionally normal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. With or without a hearing aid(s), is the subject's hearing functionally normal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

SHORT PHYSICAL PERFORMANCE BATTERY	
<p>KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>95 = Physical problem</p> <p>97 = Other problem</p> </div> <div style="width: 45%;"> <p>96 = Cognitive/behavior problem</p> <p>98 = Verbal refusal</p> </div> </div>	
1. Balance Test Score: <i>Side-by-side, semi-tandem, tandem:</i>	____ [0-4, 95-98]
2. Gait Speed Test Score:	____ [0-4, 95-98]
3. Chair Stand Test Score:	____ [0-4, 95-98]

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>NEUROLOGICAL EXAM</u>
<p>Was the Neurological Exam performed?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If No, please provide the primary reason:</p> <p><input type="checkbox"/> Physical problem <input type="checkbox"/> Verbal refusal</p> <p><input type="checkbox"/> Cognitive/behavior problem <input type="checkbox"/> Other problem (specify): _____</p> <p>_____</p>
<p>Date of Collection: ____ / ____ / ____ (MM/DD/YYYY)</p>

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

PARKINSONIAN FEATURES			
Were Parkinsonian signs present? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Parkinsonian Signs: LEFT	No	Yes	Not Assessed
1. Resting tremor - arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Slowing of fine motor movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Rigidity - arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsonian Signs: RIGHT	No	Yes	Not Assessed
4. Resting tremor - arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Slowing of fine motor movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Rigidity - arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsonian Signs	No	Yes	Not Assessed
7. Bradykinesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Parkinsonian gait disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Postural instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID Follow-up Paper CRF Package

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? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Findings consistent with stroke / cerebrovascular disease	No	Yes	Not Assessed
1. Cortical cognitive deficit (e.g., aphasia, apraxia, neglect)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Findings consistent with stroke / cerebrovascular disease: LEFT SIDE OF BODY	No	Yes	Not Assessed
2. Lateralized motor weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cortical visual field loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Somatosensory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Findings consistent with stroke / cerebrovascular disease: RIGHT SIDE OF BODY	No	Yes	Not Assessed
6. Lateralized motor weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cortical visual field loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Somatosensory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is magnetic gait apraxia present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Higher cortical visual problem suggesting posterior cortical atrophy (e.g., prosopagnosia, simultagnosia, Balint's syndrome) or apraxia of gaze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Findings suggestive of progressive supranuclear palsy (PSP), corticobasal syndrome, or other related disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Findings suggesting ALS (e.g., muscle wasting, fasciculations, upper motor neuron and/or lower motor neuron signs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>COGNITIVE DIAGNOSIS</u>					
Date of Evaluation: ____ / ____ / _____ (MM/DD/YYYY)					
SYNDROMIC DIAGNOSIS					
<input type="checkbox"/> Normal Cognition <input type="checkbox"/> Impaired, Not MCI <input type="checkbox"/> MCI <input type="checkbox"/> Dementia					
Age of Onset: ____ <input type="checkbox"/> Unknown					
PRIMARY ETIOLOGICAL DIAGNOSES	Present		Primary	Contributing	Non-contributing
	No	Yes			
1. Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Lewy body disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2a. Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>			
3. Vascular brain injury (based on clinical or imaging evidence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3a. Peri-Ventricular Fazekas Extent Grade	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Unknown/ N/A
3b. Deep Fazekas Extent Grade	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Unknown/ N/A
3c. Deep Fazekas Lesion Count Grade	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Unknown/ N/A
	Present		Primary	Contributing	Non-contributing
	No	Yes			
4. Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Present: 4a. If present, does the subject have symptoms consistent with chronic traumatic encephalopathy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown		

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Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

	Present		Primary	Contributing	Non-contributing
	No	Yes			
5. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Present: 5a. <input type="checkbox"/> Untreated <input type="checkbox"/> Treated with medication and/or counseling					
	Present		Primary	Contributing	Non-contributing
	No	Yes			
6. Cognitive impairment due to alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Present: 6a. Current alcohol abuse	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

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

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

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

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>MoCA (MONTREAL COGNITIVE ASSESSMENT)</u>				
<p>Was any part of the MoCA administered?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes </p> <p style="margin-left: 40px;"> If No, please provide the primary reason: <input type="checkbox"/> Physical problem <input type="checkbox"/> Verbal refusal </p> <p> <input type="checkbox"/> Cognitive/behavior problem <input type="checkbox"/> Other problem (specify): _____ </p> <p>_____</p>				
Date of Examination: ____ / ____ / _____ (MM/DD/YYYY)				
Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Video				
Language of test administration: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify): _____				
<p>KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">95 = Physical problem</td> <td style="width: 50%;">96 = Cognitive/behavior problem</td> </tr> <tr> <td>97 = Other problem</td> <td>98 = Verbal refusal</td> </tr> </table>	95 = Physical problem	96 = Cognitive/behavior problem	97 = Other problem	98 = Verbal refusal
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]				

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

6. Language — Naming:	___ [0-3, 95-98]
7. Memory — Registration (two trials):	___ [0-10, 95-98]
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: <i>(if not completed, enter reason code and skip to question 17)</i>	___ [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]

MarkVCID Follow-up Paper CRF Package

Patient ID: ____ _	Patient Initials: ____ _
Visit Date: ____/____/____	Evaluator Initials: ____ _
Study Visit:	

<u>Blind MoCA (MONTREAL COGNITIVE ASSESSMENT)</u>
<p>Was any part of the Blind MoCA administered?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="padding-left: 40px;">If No, please provide the primary reason: <input type="checkbox"/> Physical problem <input type="checkbox"/> Verbal refusal</p> <p><input type="checkbox"/> Cognitive/behavior problem <input type="checkbox"/> Other problem (specify): _____</p> <p>_____</p>
<p>Date of Examination: ____ / ____ / ____ (MM/DD/YYYY)</p>
<p>Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Phone</p>
<p>Language of test administration:</p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other (specify): _____</p>
<p>KEY: If the subject cannot complete any of the following exams, please give the reason by entering one of the following codes:</p> <p style="padding-left: 40px;">95 = Physical problem 96 = Cognitive/behavior problem</p> <p style="padding-left: 40px;">97 = Other problem 98 = Verbal refusal</p>
<p>7. Memory — Registration (two trials): ____ [0-10, 95-98]</p>
<p>8. Attention — Digits: ____ [0-2, 95-98]</p>
<p>9. Attention — Letter A: ____ [0-1, 95-98]</p>
<p>10. Attention — Serial 7s: ____ [0-3, 95-98]</p>
<p>11. Language — Repetition: ____ [0-2, 95-98]</p>

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

12. Language — Fluency:	____ [0-1, 95-98]
13. Abstraction:	____ [0-2, 95-98]
14. Delayed recall — No cue: <i>(if not completed, enter reason code and skip to question 17)</i>	____ [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]

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>NEUROPSYCHOLOGICAL TESTING BATTERY</u>
<p>Was any part of the Neuropsychological Testing Battery administered?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If No, please provide the primary reason: <input type="checkbox"/> Physical problem <input type="checkbox"/> Verbal refusal</p> <p><input type="checkbox"/> Cognitive/behavior problem <input type="checkbox"/> Other problem (specify): _____</p> <p>_____</p>
<p>Date of Examination: ____ / ____ / _____ (MM/DD/YYYY)</p>
<p>Language of test administration:</p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other (specify): _____</p>

MarkVCID Follow-up Paper CRF Package

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:

- | | |
|--|---------------------------------|
| 94 = Test not administered as part of battery at this session (where applicable) | 96 = Cognitive/behavior problem |
| 95 = Physical problem | 97 = Other problem |
| | 98 = Verbal refusal |

<p>1. Craft Story 21 Recall (Immediate):</p> <p>a) If test not completed, enter reason code and skip to question 2a: ____ [95-98]</p> <p>b) Total story units recalled, verbatim scoring: ____ [0-44]</p> <p>c) Total story units recalled, paraphrase scoring: ____ [0-25]</p> <p>Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Video <input type="checkbox"/> Phone</p>
<p>2. Craft Story 21 Recall (Delayed):</p> <p>a) If test not completed, enter reason code and skip to question 3a: ____ [95-98]</p> <p>b) Total story units recalled, verbatim scoring: ____ [0-44]</p> <p>c) Total story units recalled, paraphrase scoring: ____ [0-25]</p> <p>d) Delay time (minutes): <input type="checkbox"/> Unknown ____ [0-85]</p> <p>e) Cue ("boy") needed: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>3. Number Span Test — Forward:</p> <p>a) If test not completed, enter reason code and skip to question 4a: ____ [95-98]</p> <p>b) Number of correct trials: ____ [0-14]</p> <p>c) Longest span forward: ____ [0, 3-9]</p> <p>Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Video <input type="checkbox"/> Phone</p>
<p>4. Number Span Test — Backward:</p> <p>a) If test not completed, enter reason code and skip to question 5a: ____ [95-98]</p> <p>b) Number of correct trials: ____ [0-14]</p> <p>c) Longest span backward: ____ [0, 2-8]</p>
<p>5. Category Fluency – Animals:</p> <p>a) If test not completed, enter reason code and skip to question 6a: ____ [95-98]</p> <p>b) Total number of animals named in 60 seconds: ____ [0-77]</p> <p>Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Video <input type="checkbox"/> Phone</p>

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<p>6. Verbal Fluency – Phonemic Tests (words beginning with F):</p> <p>a) If test not completed, enter reason code and skip to question 7a: ____ [95-98]</p> <p>b) Number of correct F-words generated in 1 minute: ____ [0-40]</p> <p>c) Number of F-words repeated in 1 minute: ____ [0-15]</p> <p>d) Number of non-F-words and rule violation errors in 1 minute: ____ [0-15]</p>
<p>7. Trail Making Test A:</p> <p>a) If test not completed, enter reason code and skip to question 8a: ____ [94-98]</p> <p>b) Total number of seconds to complete (if not finished by 150 seconds, enter 150) ____ [0-150]</p> <p style="padding-left: 20px;">i. Number of commission errors: ____ [0-40]</p> <p style="padding-left: 20px;">ii. Number of correct lines: ____ [0-24]</p>
<p>8. Trail Making Test B:</p> <p>a) If test not completed, enter reason code and skip to question 9a: ____ [94-98]</p> <p>b) Total number of seconds to complete (if not finished by 300 seconds, enter 300): ____ [0-300]</p> <p style="padding-left: 20px;">i. Number of commission errors: ____ [0-40]</p> <p style="padding-left: 20px;">ii. Number of correct lines: ____ [0-24]</p>
<p>9. Multilingual Naming Test (MINT):</p> <p>a) If test not completed, enter reason code and skip to question 10a: ____ [94-98]</p> <p>b) Total score (9c+ 9e): ____ [0-32]</p> <p>c) Total correct without any cues (Uncued): ____ [0-32]</p> <p>d) Semantic cues – Number given: ____ [0-32]</p> <p>e) Semantic cues – Number correct with cue: <input type="checkbox"/> N/A ____ [0-32]</p> <p>f) Phonemic cues – Number given: ____ [0-32]</p> <p>g) Phonemic cues – Number correct with cue: <input type="checkbox"/> N/A ____ [0-32]</p> <p>Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Video</p>

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<p>10. Word list learning with immediate/delay/recognition:</p> <p>a) Name of test: <input type="checkbox"/> HVLT <input type="checkbox"/> CVLT <input type="checkbox"/> CVLT-SF <input type="checkbox"/> SEVLT [Spanish] <input type="checkbox"/> Other (specify): _____</p> <p>b) Total number of words on list: _____</p> <p>c) If test not completed, enter reason code and skip to question 11a: ____ [95-98]</p> <p>d) Learning Trial 1: _____</p> <p>e) Learning Trial 2: _____</p> <p>f) Learning Trial 3: _____</p> <p>g) Learning Trial 4: <input type="checkbox"/> N/A _____</p> <p>h) Learning Trial 5: <input type="checkbox"/> N/A _____</p> <p>i) Delay duration (if multiple options choose longest): _____</p> <p>j) Delayed recall (if multiple delay options, choose longest): _____</p> <p>k) Recognition hits: _____</p> <p>l) Recognition false positives: _____</p> <p>Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Video <input type="checkbox"/> Phone</p>
<p>11. Verbal Naming:</p> <p>a) If test not completed, enter reason code and skip to question 12a: ____ [94-98]</p> <p>b) Total correct without a cue: _____ [0-50]</p> <p>c) Total correct with phonemic cue: _____ [0-50]</p>

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<p>12. Oral Trail Making Test A:</p> <p>a) If test not completed, enter reason code and skip to question 13a: ____ [94-98]</p> <p>b) Total number of seconds to complete (if not finished by 100 seconds, enter 100)</p> <p style="text-align: right;">_____ [0-100]</p> <p style="padding-left: 40px;">i. Number of errors: _____ [0-25]</p> <p style="padding-left: 40px;">ii. Total number correct: _____ [0-25]</p> <p>Method of Administration: <input type="checkbox"/> In-person <input type="checkbox"/> Video <input type="checkbox"/> Phone</p>
<p>13. Oral Trail Making Test B:</p> <p>a) If test not completed, enter reason code: _____ [94-98]</p> <p>b) Total number of seconds to complete (if not finished by 300 seconds, enter 300)</p> <p style="text-align: right;">_____ [0-300]</p> <p style="padding-left: 40px;">i. Number of errors: _____ [0-25]</p> <p style="padding-left: 40px;">ii. Total number correct: _____ [0-25]</p>

MarkVCID Follow-up Paper CRF Package

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)

Method of Administration: In-person Video Phone

Section 1: Standard CDR

<i>Please enter score below:</i>	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	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

MarkVCID Follow-up Paper CRF Package

Patient ID: _ _ _ _ _	Patient Initials: _ _ _
Visit Date: _ _ / _ _ / _ _ _ _	Evaluator Initials: _ _ _
Study Visit:	

_ . _	relation to past performance				
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				

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

Section 2: Supplemental CDR					
<i>Please enter score below:</i>	IMPAIRMENT				
	None - 0	Questionable - 0.5	Mild - 1	Moderate - 2	Severe - 3
1. Behavior, comporment, and personality ____ . ____	Socially appropriate behavior	Questionable changes in comporment, 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

MarkVCID Follow-up Paper CRF Package

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you dropped many of your activities and interests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel that your life is empty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you often get bored?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you in good spirits most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you afraid that something bad is going to happen to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel happy most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you often feel helpless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID Follow-up Paper CRF Package

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel you have more problems with memory than most people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you think it is wonderful to be alive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you feel pretty worthless the way you are now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you feel full of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel that your situation is hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you think that most people are better off than you are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>LABORATORY TESTS</u>		
Date of Collection: ____ / ____ / ____ (MM/DD/YYYY)		
<p>PHYSIOLOGIC MEASURES</p> <p><i>Only enter test results from labs conducted within the last 3 months. Individual dates labs were conducted will not be captured. Please enter the date the lab data was collected or retrieved from medical records for 'Date of Collection.'</i></p> <p><i>If fasting conditions are unknown, mark "not fasting".</i></p> <p><i>All tests denoted with * are required. Cholesterol related labs, blood sugar, and homocysteine should be collected under fasting conditions when possible.</i></p>		
Measure	Fasting	Result
1. HS-CRP	N/A	____ mg/L <input type="checkbox"/> Not Done
2. HbA1c	N/A	____ mmol/mol <input type="checkbox"/> Not Done
3. Blood Sugar*	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	____ mmol/L <input type="checkbox"/> Not Done
4. Serum cholesterol*	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	____ mg/dL <input type="checkbox"/> Not Done
5. HDL cholesterol*	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	____ mg/dL <input type="checkbox"/> Not Done
6. LDL cholesterol*	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	____ mg/dL <input type="checkbox"/> Not Done
7. Triglycerides*	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	____ mg/dL <input type="checkbox"/> Not Done
8. Homocysteine	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	____ mg/dL <input type="checkbox"/> Not Done
9. Serum creatinine*	N/A	____ mg/dL <input type="checkbox"/> Not Done

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

GENETICS
Have any genetic tests been performed? If this is a follow up visit, only answer for any new tests performed. <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes:
APOE genotype: <input type="checkbox"/> E2/E2 <input type="checkbox"/> E2/E3 <input type="checkbox"/> E2/E4 <input type="checkbox"/> E3/E3 <input type="checkbox"/> E3/E4 <input type="checkbox"/> E4/E4 <input type="checkbox"/> Not Done
Has a GWAS been completed? <input type="checkbox"/> No <input type="checkbox"/> Yes

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>SAMPLE COLLECTION: CSF COLLECTION</u>
Status: <input type="checkbox"/> Collected <input type="checkbox"/> Not Collected
<p style="text-align: center;">If not collected, reason not collected: _____</p> <p style="text-align: center;">_____</p>
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)
<p>Pre-Centrifugation sample:</p> <p>Appearance: <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy</p> <p>Color: <input type="checkbox"/> Pink <input type="checkbox"/> Other (specify): _____</p> <p style="text-align: center;">_____</p>
Number of 0.25 mL aliquots: ____

MarkVCID Follow-up Paper CRF Package

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 -80° 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): _____

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>SAMPLE COLLECTION: PLASMA COLLECTION</u>
Status: <input type="checkbox"/> Collected <input type="checkbox"/> Not Collected
<p style="text-align: center;">If not collected, reason not collected: _____</p> <p style="text-align: center;">_____</p>
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? <input type="checkbox"/> No <input type="checkbox"/> Yes
Storage temperature: ____ °C

MarkVCID Follow-up Paper CRF Package

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 -80° 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): _____

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>SAMPLE COLLECTION: SERUM COLLECTION</u>
Status: <input type="checkbox"/> Collected <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes
Storage temperature: ____ °C

MarkVCID Follow-up Paper CRF Package

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 -80° 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): _____

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>SAMPLE COLLECTION: PLATELET POOR PLASMA (PPP) COLLECTION</u>
Status: <input type="checkbox"/> Collected <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes
Storage temperature: ____ °C

MarkVCID Follow-up Paper CRF Package

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

MarkVCID Follow-up Paper CRF Package

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 -80° 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): _____

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>IMAGING</u>	
Was an MRI performed at this visit?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If No , please provide reason:	<input type="checkbox"/> Claustrophobia <input type="checkbox"/> Other reason: _____ _____
Date of Imaging: ____ / ____ / ____ (MM/DD/YYYY)	

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>OCTA SCREENING WORKSHEET</u>			
Date of OCTA Screening: ____ / ____ / ____ (MM/DD/YYYY)			
Exclusion Criteria <i>If the subject answers "yes" to any questions under #1-4, please DO NOT perform OCTA testing on the subject.</i>			
Criterion	No	Yes	N/A
1. Have you ever been diagnosed with any of the following eye diseases?			
1.1. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
1.2. Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	
1.3. <u>Advanced</u> Dry Age-Related Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
1.4. <u>Advanced</u> Wet Age-Related Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you ever had any of the following procedures done?			
2.1. Laser Surgery on either eye for any reason (<i>excluding cosmetic or refractive procedures such as LASIK or cataract surgery</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
2.2. Injections into or around either eye (<i>excluding cosmetic procedures</i>)	<input type="checkbox"/>	<input type="checkbox"/>	

MarkVCID Follow-up Paper CRF Package

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 (<u>excluding</u> blurry vision)? <i>(Mark not applicable if patient has never had their eyes dilated for an eye examination)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.2. Were you told not to get dilated again? <i>(Mark not applicable if patient has never had their eyes dilated for an eye examination)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you take any prescription eye drops (excluding artificial tears)?	<input type="checkbox"/>	<input type="checkbox"/>	
OCTA Enrollment			
<input type="checkbox"/> Subject cannot undergo OCTA testing because of exclusion criteria <input type="checkbox"/> 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			

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>OCTA: INITIAL OR ANNUAL FOLLOW-UP</u>

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	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 3	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 4	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 1	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 3	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 4	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 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	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 3	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 4	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 1	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 3	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 4	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

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

MarkVCID Follow-up Paper CRF Package

Patient ID: _____	Patient Initials: _____
Visit Date: ____/____/____	Evaluator Initials: _____
Study Visit:	

<u>OCTA: TEST/RETEST - SAME DAY</u>
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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	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 2	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 3	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 4	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 1	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 2	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 3	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 4	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 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	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 2	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 3	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 4	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 1	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 2	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 3	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 4	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done

MarkVCID Follow-up Paper CRF Package

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	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 2	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 3	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Angiography 3x3 mm Scan 4	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 1	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 2	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 3	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Not Done
Right Eye Optic Disc Cube 200x200 Scan 4	<input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 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	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 2	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 3	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Angiography 3x3 mm Scan 4	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
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Left Eye Optic Disc Cube 200x200 Scan 3	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done
Left Eye Optic Disc Cube 200x200 Scan 4	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> Not Done