MarkVCID Paper Case Report Form Initial Package

Version 6.0, February 5, 2020
MarkVCID Consortium

MarkVCID Paper CRF Initial Package

Contents

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

<table>
<tr><td colspan="2" align="center"><u>DEMOGRAPHICS AND RELATED ELEMENTS</u></td></tr>
<tr><td colspan="2">Date of Birth: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)
NOTE: DOB is only entered in the registration form and used to calculate the age. DOB is not saved in the data system</td></tr>
<tr><td colspan="2">Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)</td></tr>
<tr><td colspan="2">1. Sex: ☐ Male   ☐ Female</td></tr>
<tr><td colspan="2">2. Does the subject report being of Hispanic/Latino ethnicity (i.e., having origins from a mainly Spanish-speaking Latin American country), regardless of race?
☐ No   ☐ Yes   ☐ Unknown

2a. If yes, what are the subject's reported origins?

☐ Mexican, Chicano, or Mexican-American

☐ Puerto Rican

☐ Cuban

☐ Dominican

☐ Central American

☐ South American

☐ Other (specify): _____

☐ Unknown</td></tr>
</table>

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3. What does the subject report as his or her race?

☐ White

☐ Black or African American

☐ American Indian or Alaska Native

☐ Native Hawaiian or other Pacific Islander

☐ Asian

☐ Other (specify): _____

☐ Unknown

4. What additional race does the subject report?

☐ White

☐ Black or African American

☐ American Indian or Alaska Native

☐ Native Hawaiian or other Pacific Islander

☐ Asian

☐ Other (specify): _____

☐ None reported

☐ Unknown

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Study Visit:	

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5. What additional race, beyond those reported above, does the subject report?

☐ White

☐ Black or African American

☐ American Indian or Alaska Native

☐ Native Hawaiian or other Pacific Islander

☐ Asian

☐ Other (specify): _____

☐ None reported

☐ Unknown

6. Subject's primary language:

☐ English

☐ Spanish

☐ Mandarin

☐ Cantonese

☐ Russian

☐ Japanese

☐ Other primary language (specify): _____

☐ Unknown

6a. If English is not the subject's primary language, is the subject fluent in English?

☐ No ☐ Yes ☐ Unknown

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7. Is the subject left- or right-handed (for example, which hand would s/he normally use to write or throw a ball)?

☐ Left-handed

☐ Right-handed

☐ Ambidextrous

☐ Unknown

8. Subject's current marital status:

☐ Married   ☐ Never married (or marriage was annulled)

☐ Widowed   ☐ Living as married/domestic partner

☐ Divorced   ☐ Unknown

☐ Separated

9. 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:** ___ ___ ___
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10. 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

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

12. Occupation during most of working career:

Occupation Category Number: _____

Occupation: _____

If other, specify: _____

13. Subject's years of education — use the codes below to report the level achieved;

if an attempted level is not completed, enter the number of years

completed: __ __   ☐ Unknown

(12 = high school or GED, 16 = bachelor's degree, 18 = master's degree,
20 = doctorate)

Patient ID: __ __ __ __ __ __ __ __ __ __

Patient Initials: ____ ____ ____

Visit Date: ___ ___/ ___ ___/ ___ ___ ___ ___

Evaluator Initials: ____ ____ ____

Study Visit:

MEDICAL/NEUROLOGICAL/PSYCHIATRIC HISTORY

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

HISTORY OF CIGARETTE SMOKING

	No	Yes	Unknown
1. Has the subject smoked within the last 30 days?	☐	☐	☐
2. Has the subject smoked more than 100 cigarettes in her/his life?	☐	☐	☐

If Yes:

2a. Total years smoked: __ __ [0-87]   ☐ Unknown

2b. Average number of packs smoked per day:
   ☐ 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

2c. If the subject has quit smoking, specify that age at which he/she last smoked

(i.e., quit):   __ __ __ [8-110]   ☐ N/A   ☐ Unknown

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Visit Date: ___ ___/ ___ ___/ ___ ___ ___ ___	Evaluator Initials: ____ ____ ____
Study Visit:	

CARDIOVASCULAR DISEASE	Absent	Recent/active	Remote/inactive	Unknown
1. Heart attack/cardiac arrest	☐	☐	☐	☐
If not Absent or Unknown:				
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	☐	☐	☐	☐
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) _____	☐	☐	☐	☐

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Study Visit:	

CEREBROVASCULAR HISTORY			
History of Symptomatic Stroke/ Acute Vascular Event? ☐ No ☐ Yes ☐ Unknown			
If yes, complete the following:			
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

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

NEUROLOGIC CONDITIONS				
Condition	Absent	Recent/active	Remote/inactive	Unknown
1. Seizures	☐	☐	☐	☐
2. Traumatic brain injury (TBI)	☐	☐	☐	☐
If TBI recent/active or remote/inactive:				
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				

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Visit Date: ___ ___/ ___ ___/ ___ ___ ___ ___	**Evaluator Initials:** ___ ___ ___
Study Visit:	

MEDICAL CONDITIONS				
Condition	Absent	Recent/active	Remote/inactive	Unknown
1. Diabetes	☐	☐	☐	☐
1a. If recent/active or remote/inactive, which type? ☐ Type 1 ☐ Type 2 ☐ Other type (diabetes insipidus, ☐ Unknown latent autoimmune diabetes/ type 1.5, gestational diabetes)				
1b. Age of onset: __ __ ☐ Unknown				
2. Hypertension	☐	☐	☐	☐
2a. If recent/active or remote/inactive, is hypertension treated? ☐ No ☐ Yes				
2b. Age of onset: __ __ ☐ Unknown				
3. Hypercholesterolemia	☐	☐	☐	☐
3a. Age of onset: __ __ ☐ Unknown				
4. B12 deficiency	☐	☐	☐	☐
5. Thyroid disease	☐	☐	☐	☐
6. Arthritis	☐	☐	☐	☐
If recent/active or remote/inactive:				
6a. Type of arthritis: ☐ Rheumatoid ☐ Osteoarthritis ☐ Other (specify): _____ ☐ Unknown				
6b. Region(s) affected (check all that apply): ☐ Upper extremity ☐ Lower extremity ☐ Spine ☐ Unknown				
7. Incontinence – urinary	☐	☐	☐	☐
8. Incontinence – bowel	☐	☐	☐	☐
9. Sleep apnea	☐	☐	☐	☐
9a. Age of onset: __ __ ☐ Unknown				
10. REM sleep behavior disorder (RBD)	☐	☐	☐	☐
11. Hyposomnia/insomnia	☐	☐	☐	☐

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

SUBSTANCE ABUSE				
Substance Abuse	Absent	Recent/active	Remote/inactive	Unknown
1. Alcohol abuse: clinically significant impairment occurring over a 12-month period manifested in one of the following areas: work, driving, legal, or social	☐	☐	☐	☐
2. Other abused substances: clinically significant impairment occurring over a 12-month period manifested in one of the following areas: work, driving, legal, or social	☐	☐	☐	☐
2a. If recent/active or remote/inactive, specify abused substance: _____ _____				

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

PSYCHIATRIC CONDITIONS, DIAGNOSED OR TREATED BY A PHYSICIAN				
Psychiatric Condition	Absent	Recent/active	Remote/inactive	Unknown
1. Post-traumatic stress disorder (PTSD)	☐	☐	☐	☐
2. Bipolar disorder	☐	☐	☐	☐
3. Schizophrenia	☐	☐	☐	☐
4. Depression				

4a. Active depression in the last two years
☐ No
☐ Yes
☐ Unknown

4b. Depression episodes more than two years ago
☐ No
☐ Yes
☐ Unknown

5. Anxiety	☐	☐	☐	☐
6. Obsessive-compulsive disorder (OCD)	☐	☐	☐	☐
7. Developmental neuropsychiatric disorders (e.g., autism spectrum disorder [ASD], attention-deficit hyperactivity disorder [ADHD], dyslexia)	☐	☐	☐	☐
8. Other psychiatric disorders	☐	☐	☐	☐

8a. If recent/active or remote/inactive, specify disorder: _____

_____

MEDICAL HISTORY

1. Does the subject ever cry or laugh apparently involuntarily, spontaneously or out-of-proportion to the situation?
☐ No
☐ Yes
☐ Unknown

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Study Visit:	

FAMILY HISTORY

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?	☐	☐	☐
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?	☐	☐	☐

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

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

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Study Visit:	

<table>
<tr><td colspan="4" align="center"><u>GENERAL PHYSICAL MEASURES</u></td></tr>
<tr><td colspan="4">Were General Physical Measures performed?

☐ No   ☐ Yes

    If No, please provide the primary reason:

☐ Physical problem   ☐ Verbal refusal

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

_____</td></tr>
<tr><td colspan="4">Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)</td></tr>
</table>

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?	☐	☐	☐

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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]

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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	☐	☐	☐

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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	☐	☐	☐

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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 No	Present Yes	Primary	Contributing	Non-contributing
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 No	Present Yes	Primary	Contributing	Non-contributing
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	

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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:

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]

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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): _____

MarkVCID Paper CRF Initial 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:

    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]

MarkVCID Paper CRF Initial Package

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: __ __

MarkVCID Paper CRF Initial 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)

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

MarkVCID Paper CRF Initial Package

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

MarkVCID Paper CRF Initial 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?	☐	☐	☐
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?	☐	☐	☐

MarkVCID Paper CRF Initial Package

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

<table>
<tr><td colspan="4" align="center"><u>LABORATORY TESTS</u></td></tr>
<tr><td colspan="4">Date of Collection: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)</td></tr>
<tr><td colspan="4">PHYSIOLOGIC MEASURES
<i>If fasting conditions are unknown, mark "not fasting".</i>
<i>All tests denoted with * are required. Cholesterol related labs, blood sugar, and homocysteine should be collected under fasting conditions when possible.</i></td></tr>
<tr><td align="center">Measure</td><td align="center">Fasting</td><td colspan="2" align="center">Result</td></tr>
<tr><td>1. HS-CRP</td><td>N/A</td><td>_ _ _ mg/L</td><td>☐ Not Done</td></tr>
<tr><td>2. HbA1c*</td><td>N/A</td><td>_ _ _ mmol/mol</td><td>☐ Not Done</td></tr>
<tr><td>3. Blood Sugar</td><td>☐ Fasting >8 hours
☐ Not fasting</td><td>_ _ _ mmol/L</td><td>☐ Not Done</td></tr>
<tr><td>4. Serum cholesterol*</td><td>☐ Fasting >8 hours
☐ Not fasting</td><td>_ _ _ mg/dL</td><td>☐ Not Done</td></tr>
<tr><td>5. HDL cholesterol*</td><td>☐ Fasting >8 hours
☐ Not fasting</td><td>_ _ _ mg/dL</td><td>☐ Not Done</td></tr>
<tr><td>6. LDL cholesterol*</td><td>☐ Fasting >8 hours
☐ Not fasting</td><td>_ _ _ mg/dL</td><td>☐ Not Done</td></tr>
<tr><td>7. Triglycerides*</td><td>☐ Fasting >8 hours
☐ Not fasting</td><td>_ _ _ mg/dL</td><td>☐ Not Done</td></tr>
<tr><td>8. Homocysteine</td><td>☐ Fasting >8 hours
☐ Not fasting</td><td>_ _ _ mg/dL</td><td>☐ Not Done</td></tr>
<tr><td colspan="4">GENETICS</td></tr>
<tr><td colspan="4">Have any genetic tests been performed? ☐ No   ☐ Yes</td></tr>
<tr><td colspan="4">If yes:</td></tr>
<tr><td colspan="4">APOE genotype: ☐ E2/E2   ☐ E2/E3   ☐ E2/E4

   ☐ E3/E3   ☐ E3/E4   ☐ E4/E4   ☐ Not Done</td></tr>
<tr><td colspan="4">Has a GWAS been completed?   ☐ No   ☐ Yes</td></tr>
</table>

MarkVCID Paper CRF Initial Package

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: __ __

MarkVCID Paper CRF Initial 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 -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): _____

_____

_____

MarkVCID Paper CRF Initial Package

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

MarkVCID Paper CRF Initial 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 -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): _____

_____

_____

MarkVCID Paper CRF Initial Package

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

MarkVCID Paper CRF Initial 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 -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): _____

_____

_____

MarkVCID Paper CRF Initial Package

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

MarkVCID Paper CRF Initial 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 Paper CRF Initial 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 -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): _____

_____

_____

MarkVCID Paper CRF Initial Package

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)

MarkVCID Paper CRF Initial Package

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. <u>Advanced</u> Dry Age-Related Macular Degeneration	☐	☐	
1.4. <u>Advanced</u> 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)*	☐	☐	

MarkVCID Paper CRF Initial 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)? (*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			

MarkVCID Paper CRF Initial Package

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

OCTA: INITIAL

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 Paper CRF Initial 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

MarkVCID Paper CRF Initial Package

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	

MarkVCID Paper CRF Initial Package

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 Paper CRF Initial 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
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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

MarkVCID Paper CRF Initial 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	☐ 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
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MarkVCID Paper CRF Initial Package

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

Scan Number	Signal Strength			
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Left Eye Optic Disc Cube 200x200 Scan 1	☐ 8	☐ 9	☐ 10	☐ Not Done
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MarkVCID Paper CRF Initial Package

Patient ID: __ __ __ __ __ __ __ __ __ __   **Patient Initials:** ____ ____ ____

Visit Date: ___ ___/ ___ ___/ ___ ___ ___ ___   **Evaluator Initials:** ____ ____ ____

Study Visit:

HOLLINGSHEAD INDEX

1 – Major Professionals/ Higher Executives/ Proprietors of Large Concerns
Administrator of Business
Architects
Bank Presidents
Business Owners
Certified Public Accountant
Chief Executive/CEO, CFO, COO
Clergy
Commissioned Officers in the Military
Dentists
Economists
Engineers/ Masters level and above
Executive Vice President
Lawyers/ Judges
Major Contractors
Physicians
President of a Large Company
Professor/ University Teachers
Psychologists
Research Scientists/ PhD
Veterinarians
VP of Large Business
Other/unknown major professional etc.

2 – Lesser Professionals/ Business Managers of Medium-Sized Businesses
Accountants
Advertising Executives
Art Director
Branch Managers
Building Contractors
Business Managers
Chiropractors
Computer Programmer
Database Developer
Engineers- no advanced degree
Executive Managers
Farm Owners
Furniture Business
Gallery Instructor- Museum, Art gallery
Government Officials
Jewelers
Labor Relations Consultant
Librarians
Manufacturing Owners
Mathematician
Musicians
Nurses
Office Managers
Opticians
Personnel Managers

Pharmacists
Police Chief/ Sheriff
Postmaster
Production Managers/ TV/ Radio
Public Health Officers
Purchasing Managers
Real Estate Brokers
Research Assistants
Sales Engineers
Sales Managers
School Guidance Counselor
Social Workers
Teachers/ Elementary & High School
Theatre Owners
Other or unknown lesser professional etc.

MarkVCID Paper CRF Initial Package

3 – Administrative Personnel, Small Business Owners, Minor Professionals
Actors
Administrative Assistants
Advertising Agents
Artists
Auto Claims Supervisor
Bakers
Beauty Shop Owners
Chefs
Chief Clerks
Clerk- not professionally trained
Court Reporters
Credit Managers
Department Store Manager
Deputy Sheriffs
Dispatchers
Federal and State Government Officials
Florists
Funeral Directors
Government Officials
Insurance Agents
Laboratory Assistants
Landscape Planners
Mechanical Inspector
Military NCO/Sgts
Morticians
Newspaper/ TV Reporters
Nutritionist
Oral Hygienists
Photographers
Piano Teachers
Plumbers
Quality Control
Radio/ TV Announcers

Real Estate Agents
Restaurant Owners
Sales Representatives
Service Managers
Small Business Owners
Store Managers
Surveyors
Title Searchers
Tool Designers
Traffic Managers
Travel Agents
Veterinary Assistant
Yard Masters/ Rail Road
Other or unknown admin etc.

MarkVCID Paper CRF Initial Package

4 – Clerical and Sales Workers, Technicians, Owners of Little Businesses
Bank Tellers
Bill Collectors
Bookkeepers
Clerk
Claims Examiners
Dental Technician
Draftsman
Driving Teacher
Factory Supervisors
Farmers
Flower Shop Worker
Human Resource Interviewer
Laboratory Technicians
Medical Secretary
Newsstand Operator
Post Office Clerk
R.R. Conductors
Railroad Train Engineers
Retail Clerks
Route Managers
Sales
Sales Clerks
Secretaries/ Stenographers
Shipping Clerks
Tailor
Tax Clerks
Telephone Company Worker
Telephone Operators
Timekeepers
Toll Collectors
Tower Operators
Truck Dispatchers

Typists
Utility Worker
Warehouse Clerks
Window Store Trimmers
Other or unknown clerical etc.

MarkVCID Paper CRF Initial Package

Study Visit:

5 – Skilled Manual Employees
Auto Body Repairs
Barbers
Blacksmiths
Boiler Repairmen
Bookbinders
Brewers
Bulldozer Operators
Cabinet Makers
Carpenters
Cement Layers/ Finishers
Cheese Makers
Construction Foreman
Diemakers
Electricians
Engravers
Exterminators
Firemen
Gardner's/ Landscape
Glassblowers
Glaziers
Gun Smiths
Hair Stylists
Home Repairmen
Kitchen Workers/ Cooks
Locksmiths
Machinists
Mailmen

Maintenance Foreman
Masons
Mechanics
Millwrights
Painters
Paperhangers
Patrolmen
Piano Builders
Piano Tuners
Plumbers
Policemen
Postmen
Printers
Radio/ TV Maintenance
Rail Road Brakeman
Repair
Sheet metal Workers
Ship smiths
Shoe Repairmen
Tile Layers
Tool Makers
Upholsterers
Utility Linemen
Watchmakers
Weavers
Welders
Other or unknown skilled manual etc.

Patient ID: __ __ __ __ __ __ __ __ __ __   **Patient Initials:** ____ ____ ____

Visit Date: ___ ___/ ___ ___/ ___ ___ ___ ___   **Evaluator Initials:** ____ ____ ____

Study Visit:

6 – Machine Operators and Semiskilled Employees
Apprentices (Electrician/Printers/etc.)
Assembly Line Workers
Bartenders
Building Superintendent
Bus Drivers
Cab/ Taxi Drivers
Cashiers
Cooks- Short Order
Delivery men
Dry Cleaning Pressers
Elevator Operators
Enlisted Military Personnel
Factory Machine Operators
Factory Workers
Foundry Workers
Garage and Gas Station Assistants
Greenhouse Workers
Guards, Security Watchmen
Housekeepers
Machine Operators and semiskilled
Meat Cutters/ Packers
Meter Readers
Oil Delivery Men
Practical Nurses
Pump Operators
Receivers and Checkers
Roofers
Seamstresses
Signal Men- Rail Road
Testers
Trucker Driver

Waiters/ Waitresses
Wine Bottlers
Wood Workers
Wrappers- Stores and Factories
Other or unknown semi-skilled manual etc.

7 – Unskilled Employees
Amusement Park Workers
Cafeteria Workers
Car Cleaners
Construction Laborers
Dairy Workers
Deck Hands
Domestics
Farm Helpers
Fishermen
Freight Handlers
Grave Diggers
Homemaker
Hospital Housekeepers
Janitors
Junk/ Recycle Sorters
Laundry Workers
Messengers
Peddlers
Porters
Roofer Laborers
Shoe Shiners
Stagehands
Stock Handlers
Street Cleaners
Unemployed
Unskilled Factory Workers
Unspecified Laborers
Window Cleaners
Woodchoppers
Other or unknown unskilled