



National Institutes of Health

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National Institute on Aging

# MarkVCID2 Case Report Form Package: Follow-Up Visit

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MarkVCID Consortium

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

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## MarkVCID2 CRF Package: Follow-Up Visit

Contents	
Demographics and Related Elements: Follow-Up .....	3
Medical and Neurological: Follow-Up.....	4
Cigarette Smoking.....	4
New Cardiovascular Disease Diagnosed Since Most Recent Study Visit.....	4
New Cerebrovascular Events Diagnosed Since Most Recent Study Visit.....	5
New Neurologic Conditions Diagnosed Since Most Recent Study Visit.....	6
New Medical Conditions Diagnosed Since Most Recent Study Visit .....	6
Family History: Follow-Up .....	8
General Physical Measures.....	9
Vital Signs .....	9
Additional Physical Observations .....	9
Short Physical Performance Battery .....	9
Neurological Exam.....	10
Parkinsonian Features .....	10
Cerebrovascular Features .....	11
Other Findings.....	12
Cognitive Diagnosis .....	13
MoCA (Montreal Cognitive Assessment) .....	15
Blind MoCA (Montreal Cognitive Assessment).....	17
Neuropsychological Testing Battery .....	19
Co-Participant/Informant Questionnaire .....	23
CDR (Clinical Dementia Rating) .....	24
GDS (Geriatric Depression Scale) .....	26
ECog-12 (Everyday Cognition): Participant.....	27
ECog-12 (Everyday Cognition): Informant.....	28
Neuropsychiatric Inventory Questionnaire (NPI-Q) – Informant Assessment .....	29
Laboratory Tests.....	31
Physiologic Measures .....	31
Genetics.....	31
Sample Collection: Plasma Collection .....	32
Sample Collection: Serum Collection.....	33
Imaging.....	34
Medications.....	36
Criteria For Cognitive Diagnoses .....	38

## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_\_\_\_\_

### DEMOGRAPHICS AND RELATED ELEMENTS: FOLLOW-UP

Collected?     No     Yes

Reason not collected: \_\_\_\_\_

Date of Collection: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Sex:     Male     Female

Subject's current marital status:

*Living as married may be applied to either heterosexual or same-sex relationships. Select **Unknown** only if the subject or co-participant is unable or unwilling to identify the subject's marital status.*

Married                       Never married (or marriage was annulled)

Widowed                       Living as married/domestic partner

Divorced                       Separated                       Unknown

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

What is the subject's level of independence?

*Select the box for the category that most accurately describes the level of activity the subject is able to do. If the subject or co-participant indicates that the subject is able to perform complex activities but is not doing the activities because of her/his living situation, the subject is still considered to be able to live independently.*

Able to live independently

Requires some assistance with complex activities

Requires some assistance with basic activities

Completely dependent

Unknown

ZIP Code (first three digits) of subject's primary residence: \_\_\_\_  Unknown

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### MEDICAL AND NEUROLOGICAL: FOLLOW-UP

Collected?  No  Yes

Reason not collected: \_\_\_\_\_

Date of Collection: \_ \_ / \_ \_ / \_ \_ \_ \_ (MM/DD/YYYY)

Date of Last Study Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ (MM/DD/YYYY)

### CIGARETTE SMOKING

Has the subject smoked **since their last study visit**?  No  Yes  Unknown

*If No or Unknown, skip to **Cardiovascular Disease** section*

Average number of packs smoked per day <b>since the last study visit</b> :	<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

If the subject has quit smoking **since the last study visit**, specify that age at which he/she last smoked (i.e., quit): \_ \_ \_  N/A  Unknown

*If the exact age is unknown, ask the subject and/or co-participant to estimate. If he/she still smokes, select **N/A**. If he/she cannot estimate, select **Unknown** checkbox.*

### NEW CARDIOVASCULAR DISEASE DIAGNOSED SINCE MOST RECENT STUDY VISIT

**Since the most recent study visit**, has the patient been diagnosed with any **new** cardiovascular diseases?  No  Yes

If yes:	No	Yes	Not Assessed
Heart attack/cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, more than one heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Age at most recent heart attack: \_ \_  Unknown

*If the exact age is unknown, ask the subject and/or co-participant to estimate. If he/she cannot estimate, select **Unknown** checkbox.*

Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angioplasty/ endarterectomy/ stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac bypass procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker and/or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### NEW CARDIOVASCULAR DISEASE DIAGNOSED SINCE MOST RECENT STUDY VISIT (cont.)

If yes:	No	Yes	Not Assessed
Heart valve replacement or repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of replacement/repair (select all that apply):	<input type="checkbox"/> Mitral <input type="checkbox"/> Aortic <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____		
Type of replacement (select all that apply):	<input type="checkbox"/> Bioprosthetic <input type="checkbox"/> Mechanical <input type="checkbox"/> Unknown <input type="checkbox"/> N/A		
<i>For the following three questions, ask whether the subject has been diagnosed with any <b>new</b> cardiovascular disease <b>since the last study visit</b> other than those listed above.</i>			
<i>For other cardiovascular disease, enter 'N/A' if absent</i>	<b>No</b>	<b>Yes</b>	<b>Not Assessed</b>
Other cardiovascular disease (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiovascular disease (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiovascular disease (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### NEW CEREBROVASCULAR EVENTS DIAGNOSED SINCE MOST RECENT STUDY VISIT

**Since the most recent study visit**, has the patient been diagnosed with a Symptomatic Stroke/Acute Vascular Event?     No     Yes

**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	— — <input type="checkbox"/> Unknown	<input type="checkbox"/> Ischemic <input type="checkbox"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<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"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<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"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<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"/> Stroke type unknown <input type="checkbox"/> TIA with clear ischemic mechanism <input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

### NEW NEUROLOGIC CONDITIONS DIAGNOSED SINCE MOST RECENT STUDY VISIT

Since the most recent study visit, has the patient been diagnosed with any new neurologic conditions?  No  Yes

Condition	No	Yes	Not Assessed
Essential tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pseudobulbar affect (i.e., crying or laughing that appears involuntary and out-of-proportion to the situation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic brain injury (TBI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Include any reported TBI, including mild TBI and TBI without loss of consciousness*

If TBI "yes":

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

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

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

*If the subject has experienced multiple TBIs with loss of consciousness, but the time unconscious is unknown for all instances, select **Unknown** for Questions 2a and 2b. If for any of questions 2a, 2b, or 2c, the subject knows there has definitely been at least a single instance, but is unsure whether there has been more than one, select **Single**, and revise the entry on this form to **Repeated/multiple** at a future date if more specific information is available at a future date.*

Age at most recent TBI: \_\_\_ \_\_\_  Unknown

*If exact age is unknown, ask the subject and/or co-participant to estimate. If he/she cannot estimate, select **Unknown** checkbox.*

### NEW MEDICAL CONDITIONS DIAGNOSED SINCE MOST RECENT STUDY VISIT

Since the most recent study visit, has the patient been diagnosed with any new medical conditions?  No  Yes

Condition	No	Yes	Not Assessed
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If recent/active or remote/inactive, which type?	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other type (latent autoimmune diabetes/ type 1.5, gestational diabetes) <input type="checkbox"/> Unknown		

Diagnosis of hypertension  No  Yes  Not Assessed

Is hypertension treated?  No  Yes

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_\_\_

NEW MEDICAL CONDITIONS DIAGNOSED SINCE MOST RECENT STUDY VISIT (continued)			
Condition	No	Yes	Not Assessed
Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of arthritis: <input type="checkbox"/> Rheumatoid <span style="margin-left: 100px;"><input type="checkbox"/> Osteoarthritis</span> <input type="checkbox"/> Other (specify): _____ <span style="margin-left: 50px;"><input type="checkbox"/> Unknown</span>			
<i>If subject has both rheumatoid arthritis and osteoarthritis, select <b>Rheumatoid</b>.</i>			
Region(s) affected (check all that apply): <input type="checkbox"/> Upper extremity <span style="margin-left: 50px;"><input type="checkbox"/> Lower extremity</span> <input type="checkbox"/> Spine <span style="margin-left: 50px;"><input type="checkbox"/> Unknown</span>			
Incontinence – urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence – bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REM sleep behavior disorder (RBD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyposomnia/insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### FAMILY HISTORY: FOLLOW-UP

Collected?  No  Yes

Reason not collected: \_\_\_\_\_

**Since the most recent study visit**, is any **new** information available concerning the patient's family history?  No  Yes

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"/>
<i>Select <b>Yes</b> if there are biological parents, full siblings, or biological children who have a history of symptomatic stroke and/or TIA with clear ischemic mechanism</i>			
<b>If yes:</b>			
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"/>
<i>Select <b>Yes</b> if history of stroke and/or TIA with clear ischemic mechanism appears in every known generation of one side of the family (e.g., mother's family or father's family)</i>			
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"/>
<i>Select <b>Yes</b> if there are biological parents, full siblings, or biological children who are affected by dementia, Alzheimer's disease, or have history of cognitive impairment</i>			
<b>If yes:</b>			
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"/>
<i>Select <b>Yes</b> if history of acquired cognitive impairment appears in every known generation of one side of the family (e.g., mother's family or father's family)</i>			
3. <b>If yes</b> 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: _____			
<i>Although blood relatives might have evidence for more than one genetic mutation, indicate the predominant mutation only. Evidence may be provided via family report, test, or other report or documentation. First, specify the gene. Then, indicate the mutation, if known. If the gene is not listed, select <b>Other</b> and specify the gene.</i>			
3c. Does this individual carry the mutation? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			



## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_\_\_

### GENERAL PHYSICAL MEASURES

Were General Physical Measures performed?  No  Yes

If No, please provide the primary reason:  Physical problem  Cognitive/behavior problem  
 Verbal refusal  Other problem (specify): \_\_\_\_\_

Date of Collection: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

### **VITAL SIGNS**

*If any vitals cannot be obtained, skip and select 'Not Done' in the EDC.*

1. Blood Pressure Measurement 1: \_\_\_\_ / \_\_\_\_ mmHg  Not Done  
 Blood Pressure Measurement 2: \_\_\_\_ / \_\_\_\_ mmHg  Not Done  
 Blood Pressure Measurement 3: \_\_\_\_ / \_\_\_\_ mmHg  Not Done

*Measure seated at rest. Take 3 consecutive BP readings. Average will be calculated in EDC. If blood pressure cannot be obtained, skip and select 'Not Done' in the EDC.*

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?

*Select **No** if any functional impairment exists (reduced ability to do everyday activities such as reading or watching television).*

2. With or without a hearing aid(s), is the subject's hearing functionally normal?

*Select **No** if any functional impairment exists (reduced ability to do everyday activities such as listening to the radio or television, talking with family or friends).*

### **SHORT PHYSICAL PERFORMANCE BATTERY**

***Please refer to the MarkVCID Short Physical Performance Battery Training Manual for detailed instructions on the administration of this assessment.***

**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 (not for any of the reasons 95-97)

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]

## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_\_\_\_\_

### NEUROLOGICAL EXAM

*INSTRUCTIONS: This form must be completed by a clinician with experience in assessing the neurological signs listed below and in attributing the observed findings to a particular syndrome. Please use your best clinical judgment in assigning the syndrome.*

*Use the information obtained at the neurological exam to indicate the neurological findings, using your best clinical judgment to ascribe those symptoms to a particular clinical syndrome.*

***Please complete the appropriate sections below, using your best clinical judgment in selecting findings that indicate the likely syndrome(s) that is/are present.***

Was the Neurological Exam performed?       No       Yes

If No, please provide the primary reason:       Physical problem       Cognitive/behavior problem  
 Verbal refusal       Other problem (specify): \_\_\_\_\_

Date of Collection: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

### **PARKINSONIAN FEATURES**

Were Parkinsonian signs present?       No       Yes

*If any of the parkinsonian signs listed below are present, select **Yes**. Otherwise, select **No** and skip to **Cerebrovascular Features** section*

**Resting tremor – arm:** *a definite rest tremor, even if only intermittent, is sufficient to select **Yes***

**Slowing of fine motor movements:** *refers to movements such as finger tapping, hand pronation-supination, or foot- or toe-tapping. Significant slowing, even if slight or mild, is sufficient to select **Yes**.*

**Rigidity – arm:** *rigidity should be judged on passive movement of major joints with patient relaxed in sitting position; cogwheeling and paratonia (gegenhalten) to be ignored. Any degree of rigidity is sufficient to select **Yes**.*

**Bradykinesia:** *includes combining slowness, hesitancy, decreased arm swing, small amplitude, and poverty of movement in general. Any degree of overall bradykinesia is sufficient to select **Yes**.*

**Parkinsonian gait disorder:** *features include slowing of gait, shuffling, festination, unilateral or bilateral decreased arm swing and/or tremor, slowness and difficulty on turning, and/or freezing during walking. Any degree of parkinsonian gait is sufficient to select **Yes**.*

**Postural instability:** *involves inadequate response to sudden, strong posterior displacement produced by pull on shoulders while patient is erect with eyes open and feet slightly apart; patient is prepared. Taking more than two steps or requiring the examiner to catch the subject are examples of postural instability. Any degree of postural instability is sufficient to select **Yes**.*

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

Parkinsonian Signs: <b>LEFT</b>	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: <b>RIGHT</b>	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"/>
CEREBROVASCULAR FEATURES			
Were neurological signs considered by examiner to be most likely consistent with cerebrovascular disease present? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>			
<i>If any of the signs consistent with CVD below are present, select <b>Yes</b>; otherwise, select <b>No</b> and skip to <b>Other Findings</b> section.</i>			
<b>Cortical cognitive deficit (e.g., aphasia, apraxia, neglect)</b> <b>Lateralized motor weakness:</b> indicate as present if it is suspected that there is acquired proximal or distal extremity weakness attributable to cerebrovascular ischemia. <b>Lateralized abnormal reflexes</b> (to include pathologically brisk deep tendon reflexes, Babinski signs, others): Indicate as present if it is suspected that there are brisk reflexes or increased tone attributable to cerebrovascular ischemia. <b>Cortical visual field loss:</b> involves homonymous hemianopsia or quadrantanopsia, or cortical blindness, excluding visual field loss due to optic nerve disease or injury. <b>Somatosensory loss:</b> involves sensory loss due to involvement of the cerebrum or brain stem, excluding sensory loss due to spinal-cord injury or peripheral neuropathy.			
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: <b>LEFT SIDE OF BODY</b>	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"/>

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Findings consistent with stroke / cerebrovascular disease: <b>RIGHT SIDE OF BODY</b>	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"/>
<b>OTHER FINDINGS</b>	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"/>
<i>Indicate whether gait apraxia characteristic of normal-pressure hydrocephalus or bilateral subcortical ischemia is present by selecting <b>Yes</b>. This determination should be made based on the neurological exam and does not require an MRI.</i>			
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 (CBS), 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"/>

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### COGNITIVE DIAGNOSIS

Evaluated?  No  Yes

Reason not evaluated: \_\_\_\_\_

Date of Evaluation: \_\_\_ / \_\_\_ / \_\_\_\_\_ (MM/DD/YYYY)

**SYNDROMIC DIAGNOSIS**  
*(see page 38 for diagnostic criteria)*

Normal Cognition                       Subjective cognitive decline (SCD)  
 Mild cognitive impairment (MCI)    Mild dementia

Age of Onset of SCD, MCI, or mild dementia: \_\_\_ years                       Unknown

If any of the diseases listed below are present, select **Present** and indicate whether it is a **Contributing** cause, or **not contributing** to the cognitive impairment. If any disease is present but the subject has normal cognition, select **Present** and select the **Non-contributing** box.

RELATED DIAGNOSES	Present		Contributing	Non-contributing
	No	Yes		
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular brain injury (based on clinical or imaging evidence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If present**, indicate type of vascular brain injury (select all that apply):

- Small vessel stroke(s)
- Non-small vessel stroke that does not interfere with test performance or MRI
- Non-small vessel stroke that interferes with test performance (e.g., post-stroke cognitive impairment or aphasia)\*
- Non-small vessel stroke that interferes with MRI biomarker analysis (e.g., large volume strokes)\*

Traumatic brain injury (TBI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**If present**, indicate severity (select all that apply):

- TBI that does not interfere with test performance or MRI
- TBI that interferes with test performance (e.g., post-TBI cognitive impairment or aphasia)\*
- TBI that interferes with MRI biomarker analysis (e.g., large volume traumatic lesion)\*

Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**If present:**    Mild/well-controlled                       Severe/incompletely controlled\*

Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**If present:** Current alcohol abuse                       No                       Yes\*                       Unknown

Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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CNS neoplasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**If present:**    Benign                       Malignant\*

Delirium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Post-traumatic stress disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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\*Diagnosis at this severity excluded at baseline; may appear at follow-up visit

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_\_\_

<b>RELATED DIAGNOSES</b> (Diagnoses excluded at baseline; may appear at follow-up visit)	Present	Contributing	Non-contributing
Multiple system atrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frontotemporal lobar degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prion disease (CJD, other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV-Associated Neurocognitive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or other psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lewy body disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER DIAGNOSES</b>	Present	Contributing	Non-contributing
Other psychiatric disease (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other neurologic, genetic, or infectious conditions not listed above (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic disease/medical illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive impairment due to medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive impairment NOS: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

### MoCA (MONTREAL COGNITIVE ASSESSMENT)

*Please refer to the MarkVCID Evaluator's Instructions Manual for details instructions on the administration of this assessment*

Was any part of the MoCA administered?  No  Yes

If No, please provide the primary reason:  Physical problem  Cognitive/behavior problem  
 Verbal refusal  Other problem (specify): \_\_\_\_\_

Date of Examination: \_\_\_ / \_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Method of Administration:  In-person  Video

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 (not for any of the reasons 95-97)

*Score is 'Not Assessed' if any of the MoCA items that contribute to the score are missing (i.e., items 1-6, 8-14, and 17-22). Items 7, 15, and 16 are not part of the MoCA score calculation; therefore, these items can have missing values (95, 96, 97, or 98). The MoCA Score will still be computed in the EDC as long as items 1-6, 8-14, and 17-22 are all non-missing.*

*Scores for items 1-5 correspond to the Visuospatial / executive section on the MoCA worksheet*

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]

*Score for item 6 corresponds to the Naming section on the MoCA worksheet*

6. Language — Naming: \_\_\_ [0-3, 95-98]

*Score for item 7 corresponds to the Memory section on the MoCA worksheet*

7. Memory — Registration (two trials): \_\_\_ [0-10, 95-98]

*Scores for items 8-10 correspond to the Attention section on the MoCA worksheet*

8. Attention — Digits: \_\_\_ [0-2, 95-98]

9. Attention — Letter A: \_\_\_ [0-1, 95-98]

10. Attention — Serial 7s: \_\_\_ [0-3, 95-98]

## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_\_\_\_\_

### MoCA (continued)

*Scores for items 11-12 correspond to the Language section on the MoCA worksheet*

11. Language — Repetition: \_\_\_\_\_ [0-2, 95-98]

12. Language — Fluency: \_\_\_\_\_ [0-1, 95-98]

*Score for item 13 corresponds to the Abstraction section on the MoCA worksheet*

13. Abstraction: \_\_\_\_\_ [0-2, 95-98]

*Scores for items 14-16 correspond to the Delayed Recall section on the MoCA worksheet*

14. Delayed recall — No cue: \_\_\_\_\_ [0-5, 95-98]

*(if not completed, enter reason code and skip to question 17)*

15. Delayed recall — Category cue: \_\_\_\_\_ [0-5, 95-98]

16. Delayed recall — Recognition: \_\_\_\_\_ [0-5, 95-98]

*Scores for items 17-22 correspond to the Orientation section on the MoCA worksheet*

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]



## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_\_\_\_\_

### **Blind MoCA (MONTREAL COGNITIVE ASSESSMENT)**

*Please refer to the MarkVCID Evaluator's Instructions Manual for details instructions on the administration of this assessment*

Was any part of the Blind MoCA administered?     No                       Yes

If No, please provide the primary reason:     Physical problem     Cognitive/behavior problem  
 Verbal refusal                       Other problem (specify): \_\_\_\_\_

Date of Examination: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Method of Administration:                       In-person                       Phone

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 (not for any of the reasons 95-97)

*Score is 'Not Assessed' if any of the Blind MoCA items that contribute to the score are missing (i.e., items 8-14 and 17-22). Items 7, 15, and 16 are not part of the Blind MoCA score calculation; therefore, these items can have missing values (95, 96, 97, or 98). The Blind MoCA Score will still be computed as long as items 8-14, and 17-22 are all non-missing.*

*Score for item 7 corresponds to the Memory section on the Blind MoCA worksheet*

7. Memory — Registration (two trials):                      \_\_\_\_ [0-10, 95-98]

*Scores for items 8-10 correspond to the Attention section on the Blind MoCA worksheet*

8. Attention — Digits:                      \_\_\_\_ [0-2, 95-98]

9. Attention — Letter A:                      \_\_\_\_ [0-1, 95-98]

10. Attention — Serial 7s:                      \_\_\_\_ [0-3, 95-98]

*Scores for items 11-12 correspond to the Language section on the Blind MoCA worksheet*

11. Language — Repetition:                      \_\_\_\_ [0-2, 95-98]

12. Language — Fluency:                      \_\_\_\_ [0-1, 95-98]

*Score for item 13 corresponds to the Abstraction section on the Blind MoCA worksheet*

13. Abstraction:                      \_\_\_\_ [0-2, 95-98]

**MarkVCID2 CRF Package: Follow-Up Visit**

**Patient ID:** \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Blind MoCA (continued)**

*Scores for items 14-16 correspond to the Delayed Recall section on the Blind MoCA worksheet*

14. Delayed recall — No cue: \_\_\_\_\_ [0-5, 95-98]

*(if not completed, enter reason code and skip to question 17)*

15. Delayed recall — Category cue: \_\_\_\_\_ [0-5, 95-98]

16. Delayed recall — Recognition: \_\_\_\_\_ [0-5, 95-98]

*Scores for items 17-22 correspond to the Orientation section on the Blind MoCA worksheet*

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]



## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

*Scores for items 3-4 correspond to the Number Span Test (Forward & Backward) Worksheets*

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]

Method of Administration:  In-person  Video  Phone

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]

*Scores for item 5 correspond to the Category Fluency Worksheets*

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]

Method of Administration:  In-person  Video  Phone

*Scores for item 6 correspond to the Verbal Fluency Worksheets, administered as part of the MoCA*

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]

*Scores for items 7-8 correspond to the Trail Making A & B Worksheets*

7. Trail Making Test A:

a) If test not completed, enter reason code and skip to question 8a: \_ \_ \_ [94-98]

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: \_ \_ \_ [94-98]

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]

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

*Scores for item 9 correspond to the Multilingual Naming Test (MINT) Worksheets  
If no semantic cues were given, select N/A for Question 9e.  
If no phonemic cues were given, select N/A for Question 9g.*

**9. Multilingual Naming Test (MINT):**

- a) If test not completed, enter reason code and skip to question 10a: \_\_\_ [94-98]
  - 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]
- Method of Administration:  In-person  Video

*Scores for item 10 correspond to your sites specific scoring instructions for the CVLT, CVLT-SF, HVL, SEVLT, or other with list learning with immediate/delay/recognition*

**10. Word list learning with immediate/delay/recognition:**

- a) Name of test:  HVL  CVLT  CVLT-SF  
 SEVLT [Spanish]  SEVLT [English]  AVL
  - Other (specify): \_\_\_\_\_
  - b) Total number of words on list: \_\_\_
  - c) If test not completed, enter reason code and skip to question 11a: \_\_\_ [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: \_\_\_
- Method of Administration:  In-person  Video  Phone

## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

*Scores for item 11 correspond to the Verbal Naming Test Worksheet*

11. Verbal Naming:

- a) If test not completed, enter reason code and skip to question 12a: \_\_ \_\_ [94-98]  
b) Total correct without a cue: \_\_ \_\_ [0-50]  
c) Total correct with phonemic cue: \_\_ \_\_ [0-50]

*Scores for items 12-13 correspond to the Oral Trail Making Test Parts A & B Worksheets*

12. Oral Trail Making Test A:

- a) If test not completed, enter reason code and skip to question 13a: \_\_ \_\_ [94-98]  
b) Total number of seconds to complete: \_\_ \_\_ \_\_ [0-100]  
(if not finished by 100 seconds, enter 100)  
i. Number of errors: \_\_ \_\_ [0-25]  
ii. Total number correct: \_\_ \_\_ [0-25]

Method of Administration:  In-person  Video  Phone

13. Oral Trail Making Test B:

- a) If test not completed, enter reason code: \_\_ \_\_ [94-98]  
b) Total number of seconds to complete: \_\_ \_\_ \_\_ [0-300]  
(if not finished by 300 seconds, enter 300)  
i. Number of errors: \_\_ \_\_ [0-25]  
ii. Total number correct: \_\_ \_\_ [0-25]

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### CO-PARTICIPANT/INFORMANT QUESTIONNAIRE

Collected?     No     Yes

If No, please provide reason:     Verbal refusal     Informant unavailable (specify below)  
 Other problem (specify below)

Specify reason not collected: \_\_\_\_\_

Date Collected: \_\_\_ / \_\_\_ / \_\_\_\_\_ (MM/DD/YYYY)

Language of test administration:  English     Spanish     Other (specify): \_\_\_\_\_

What is co-participant's relationship to the subject?	<input type="checkbox"/> Spouse, partner, or companion (include ex-spouse, ex-partner, fiancé(e), boyfriend, girlfriend) <input type="checkbox"/> Child (by blood or through marriage or adoption) <input type="checkbox"/> Sibling (by blood or through marriage or adoption) <input type="checkbox"/> Other relative (by blood or through marriage or adoption) <input type="checkbox"/> Friend, neighbor, or someone known through family, friends, work, or community (e.g., church) <input type="checkbox"/> Paid caregiver, health care provider, or clinician
How long has the co-participant known the subject?	<input type="checkbox"/> 1 year or less <input type="checkbox"/> 2-5 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> 10+ years
Does the co-participant live with the subject?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, approximate frequency of in-person visits?	<input type="checkbox"/> Daily <input type="checkbox"/> At least three times per week <input type="checkbox"/> Weekly <input type="checkbox"/> At least three times per month <input type="checkbox"/> Monthly <input type="checkbox"/> Less than once a month
If no, approximate frequency of telephone contact?	<input type="checkbox"/> Daily <input type="checkbox"/> At least three times per week <input type="checkbox"/> Weekly <input type="checkbox"/> At least three times per month <input type="checkbox"/> Monthly <input type="checkbox"/> Less than once a month

**MarkVCID2 CRF Package: Follow-Up Visit**

Patient ID: \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_ - \_\_\_

**CDR (CLINICAL DEMENTIA RATING)**

*Please refer to the MarkVCID Evaluator’s Instructions Manual for details instructions on the administration of this assessment*

Was the CDR administered?     No                                 Yes

If No, please provide     Physical problem     Cognitive/behavior problem  
the primary reason:     Verbal refusal             Other problem (specify): \_\_\_\_\_

Date of Evaluation: \_\_\_ / \_\_\_ / \_\_\_ (MM/DD/YYYY)

Method of Administration:     In-person     Video     Phone

Was the CDR scored with the input of an informant?     No                 Yes

Language of test administration:  English             Spanish     Other (specify): \_\_\_\_\_

**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
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

**Section 1: Standard CDR (continued)**



## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

<i>Please enter score below:</i>	IMPAIRMENT				
	None – 0	Questionable – 0.5	Mild – 1	Moderate – 2	Severe – 3
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
7. _ _ _ STANDARD CDR SUM OF BOXES ( <i>auto-calculated in EDC</i> )					
8. _ _ _ STANDARD GLOBAL CDR					
<b>Section 2: Supplemental CDR</b>					
<i>Please enter score below:</i>	IMPAIRMENT				
	None – 0	Questionable – 0.5	Mild – 1	Moderate – 2	Severe – 3
9. 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
10. 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

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### GDS (GERIATRIC DEPRESSION SCALE)

*Please refer to the MarkVCID Evaluator's Instructions Manual for details instructions on the administration of this assessment*

Was the GDS administered?     No                       Yes

If No, please provide the primary reason:     Physical problem     Cognitive/behavior problem  
 Verbal refusal                       Other problem (specify): \_\_\_\_\_

Date of Evaluation: \_\_\_ / \_\_\_ / \_\_\_\_\_ (MM/DD/YYYY)

Language of test administration:  English             Spanish     Other (specify): \_\_\_\_\_

*Scores for items 1-15 correspond to the Geriatric Depression Scale (GDS) Worksheet*

	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"/>
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"/>

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_\_\_

### ECOG-12 (EVERYDAY COGNITION): PARTICIPANT

*Please refer to the MarkVCID Evaluator's Instructions Manual for details instructions on the administration of this assessment*

Was the ECOG-12 Participant Form administered?       No       Yes

If No, please provide the primary reason:       Physical problem       Cognitive/behavior problem  
 Verbal refusal       Other problem (specify): \_\_\_\_\_

Date of Evaluation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Language of test administration:  English       Spanish       Other (specify): \_\_\_\_\_

Are you worried or believe that you are having problems with your attention, concentration, or memory?       No       Yes

Compared to 10 years ago, have there been any changes in your ability to...	Better or no change	Questionable or occasionally worse	Consistently a little worse	Consistently much worse	Don't Know or N/A
1. Remember where you have placed things (i.e glasses, keys)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Remember the current date or day of the week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Communicate thoughts in a conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Understand spoken directions or instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Read a map and help with directions when someone else is driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Find one's way around a house/building that you have visited many times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Anticipate weather changes and planning accordingly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Think ahead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Keep your living and workspace organized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Balance your checkbook/account without error?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do two things at once?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Cook or work, and talk at the same time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the questionnaire discontinued?       No       Yes

If yes, reason for discontinuation:       Refusal       Task difficulty (i.e., could not understand)  
 Impairment (i.e., visual, hearing, limb/motor problem)

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_\_\_

### ECOG-12 (EVERYDAY COGNITION): INFORMANT

*Please refer to the MarkVCID Evaluator's Instructions Manual for details instructions on the administration of this assessment*

Was the ECOG-12 Informant Form administered?       No       Yes

If No, please provide the primary reason:       Verbal refusal       Informant unavailable (specify below)  
 Other problem (specify below)

Specify reason not administered: \_\_\_\_\_

Date of Evaluation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Language of test administration:  English       Spanish       Other (specify): \_\_\_\_\_

How long have you known the participant?       <10 years       At least 10 years

Are you worried or believe that he/she is having problems with their attention, concentration, or memory?       No       Yes

Compared to 10 years ago, have there been any changes in their ability to...	Better or no change	Questionable or occasionally worse	Consistently a little worse	Consistently much worse	Don't Know or N/A
1. Remember where they have placed things (glasses, keys)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Remember the current date or day of the week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Communicate thoughts in a conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Understand spoken directions or instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Read a map and help with directions when someone else is driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Find their way around a house/building that you have visited many times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Anticipate weather changes and planning accordingly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Think ahead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Keep their living and workspace organized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Balance their checkbook/account without error?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do two things at once?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Cook or work, and talk at the same time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the questionnaire discontinued?       No       Yes

If yes, reason for discontinuation:       Refusal       Task difficulty (i.e., could not understand)  
 Impairment (i.e., visual, hearing, limb/motor problem)

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_\_\_

**NEUROPSYCHIATRIC INVENTORY QUESTIONNAIRE (NPI-Q) – INFORMANT ASSESSMENT**

*Please refer to the MarkVCID Evaluator's Instructions Manual for detailed instructions on the administration of this assessment*

Was the NPI-Q administered?       No       Yes

If No, please provide the primary reason:       Verbal refusal       Informant unavailable (specify below)  
 Other problem (specify below)

Specify reason not administered: \_\_\_\_\_

Date of Evaluation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Language of test administration:     English     Spanish     Other (specify): \_\_\_\_\_

NPI co-participant:       Spouse     Child       Other (specify): \_\_\_\_\_

Question	Yes	No	Unknown	If Yes, Severity
1. Delusions — Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
2. Hallucinations — Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
3. Agitation/aggression — Is the patient resistive to help from others at times, or hard to handle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
4. Depression/dysphoria — Does the patient seem sad or say that he/she is depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
5. Anxiety — Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
6. Elation/euphoria — Does the patient appear to feel too good or act excessively happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
7. Apathy/ indifference — Does the patient seem less interested in his/her usual activities or in the activities and plans of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

Question	Yes	No	Unknown	If Yes, Severity
8. Disinhibition — Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people’s feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
9. Irritability/lability — Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
10. Motor disturbance — Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
11. Nighttime behaviors — Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown
12. Appetite/eating — Has the patient lost or gained weight, or had a change in the type of food he/she likes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unknown

## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_\_\_\_\_

### LABORATORY TESTS

Were Laboratory Test results recorded?       No       Yes

Reason not collected: \_\_\_\_\_

*Only enter test results from labs conducted within the last 3 months.*

*If fasting conditions are unknown, mark "not fasting".*

*All tests denoted with \* are required. Cholesterol related labs, blood sugar, and homocysteine should be collected under fasting conditions when possible.*

### PHYSIOLOGIC MEASURES

Not Done	Measure	Date of Collection	Fasting	Result	Unit
<input type="checkbox"/>	1. HS-CRP	___/___/_____	N/A	_____	<input type="checkbox"/> nmol/L <input type="checkbox"/> g/L <input type="checkbox"/> mg/L
<input type="checkbox"/>	2. HbA1c*	___/___/_____	N/A	_____	<input type="checkbox"/> mmol/mol <input type="checkbox"/> %
<input type="checkbox"/>	3. Blood Sugar	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	_____	<input type="checkbox"/> mmol/L <input type="checkbox"/> mg/dL <input type="checkbox"/> mg/L
<input type="checkbox"/>	4. Serum cholesterol*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	_____	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	5. HDL cholesterol*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	_____	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	6. LDL cholesterol*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	_____	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	7. Triglycerides*	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	_____	<input type="checkbox"/> mg/dL <input type="checkbox"/> mmol/L
<input type="checkbox"/>	8. Homocysteine	___/___/_____	<input type="checkbox"/> Fasting >8 hours <input type="checkbox"/> Not fasting	_____	<input type="checkbox"/> mg/dL <input type="checkbox"/> umol/L <input type="checkbox"/> mg/L
<input type="checkbox"/>	9. Serum creatinine*	___/___/_____	N/A	_____	<input type="checkbox"/> mg/dL <input type="checkbox"/> umol/L
<input type="checkbox"/>	10. Serum cystatin C	___/___/_____	N/A	_____	<input type="checkbox"/> mg/L <input type="checkbox"/> mg/dL

### GENETICS

Have any genetic tests been performed?       No       Yes

**If yes:**

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

Has a GWAS been completed?       No       Yes

## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_\_\_\_\_

### **SAMPLE COLLECTION: PLASMA COLLECTION**

Status:  Collected  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: \_\_\_

Plasma cryovials used:  Wheaton CryoElite  
 Simport Micrewtube  
 VWR Screw-Cap Microcentrifuge (Not approved for use after 05/20/2024)  
 Other (specify): \_\_\_\_\_

Plasma cryovial volume:  0.5 ml  Other (specify): \_\_\_\_\_

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

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
  - Spun 2-3 hours after collection
  - Spun 3-4 hours after collection
  - Spun 4+ hours after collection
- Sample not spun at 2000g
  - Spun slower than 2000g
  - Spun faster than 2000g
- Sample not spun for 10 minutes
  - Spun <10 minutes
  - Spun >10 minutes
- Sample not placed on dry ice or in -80° C freezer immediately after aliquoting
  - 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): \_\_\_\_\_



## MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: \_\_\_\_\_

### **SAMPLE COLLECTION: SERUM COLLECTION**

Status:  Collected  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: \_\_\_\_

Serum cryovials used:  Wheaton CryoElite  
 Simport Micrewtube  
 VWR Screw-Cap Microcentrifuge (Not approved for use after 05/20/2024)  
 Other (specify): \_\_\_\_\_

Serum cryovial volume:  0.5 ml  Other (specify): \_\_\_\_\_

Temperature of Centrifugation: \_\_\_\_ °C

Did serum remain pink after centrifugation, indicating hemolysis?  No  Yes

Storage temperature: \_\_\_\_ °C

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
    - Sample sat <30 minutes
    - Sample sat >60 minutes
- Sample not spun at 2000g
  - Spun slower than 2000g
  - Spun faster than 2000g
- Sample not spun for 10 minutes
  - Spun <10 minutes
  - Spun >10 minutes
- Sample not placed on dry ice or in -80° C freezer immediately after aliquoting
  - 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): \_\_\_\_\_

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_\_\_\_\_

### **IMAGING**

Was an MRI performed at this visit?      No             Yes

**If no**, please provide reason:      Claustrophobia  
                                                       Other reason: \_\_\_\_\_

Date of Imaging: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_ (MM/DD/YYYY)

Were there any deviations from the imaging protocol?      No             Yes

If yes, please specify: \_\_\_\_\_

### **FAZEKAS**

Was a Fazekas score assigned?      No             Yes

Initials of Fazekas score assessor: \_\_\_ \_\_\_

Peri-Ventricular Fazekas Extent Grade:	<input type="checkbox"/> Grade 0 – No lesions <input type="checkbox"/> Grade 1 – Caps or pencil-thin lining <input type="checkbox"/> Grade 2 – Smooth haloing <input type="checkbox"/> Grade 3 – Irregular WMH extending into DWM <input type="checkbox"/> Unknown/ N/A
Deep Fazekas Extent Grade:	<input type="checkbox"/> Grade 0 – No lesions <input type="checkbox"/> Grade 1 – Punctate lesions <input type="checkbox"/> Grade 2 – Beginning confluent lesions <input type="checkbox"/> Grade 3 – Confluent lesions <input type="checkbox"/> Unknown/ N/A
Deep Fazekas Lesion Count Grade:	<input type="checkbox"/> Grade 0 – No lesions <input type="checkbox"/> Grade 1 – 1-4 lesions <input type="checkbox"/> Grade 2 – 5-9 lesions <input type="checkbox"/> Grade 3 – >9 lesions <input type="checkbox"/> Unknown/ N/A

Overall Fazekas Score : \_\_\_\_\_ *(Maximum score of Peri-Ventricular Fazekas Extent Grade and Deep Fazekas Extent Grade)*

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### LACUNES AND MICROBLEEDS

Was the scan assessed for lacunes and microbleeds?     No             Yes

Initials of lacune and microbleed assessor: \_ \_ \_

Does the participant have  $\geq 1$  lacune?     No             Yes

If  $\geq 1$  lacune, please select all the regions where lacunes are present:

Deep:      $\leq 2$               $> 2$

Lobar:      $\leq 2$               $> 2$

Does the participant have  $\geq 1$  microbleed?     No             Yes

If  $\geq 1$  microbleed, please select all the regions where microbleeds are present:

Lobar (supratentorial):      $\leq 4$               $> 4$

Deep (supratentorial):      $\leq 4$               $> 4$

Cerebellar (cortical):      $\leq 4$               $> 4$

Cerebellar (deep):      $\leq 4$               $> 4$

Brainstem:      $\leq 4$               $> 4$

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

### MEDICATIONS

Were the patient's medications recorded?       No       Yes

If not collected, reason not collected: \_\_\_\_\_

Date of Collection: \_ \_ / \_ \_ / \_ \_ \_ \_ (MM/DD/YYYY)

Is the patient currently taking any medications?       No       Yes

Currently Taking	Medication Name
<input type="checkbox"/>	acetaminophen-Hydrocodone (Vicodin)
<input type="checkbox"/>	Albuterol (Proventil, Ventolin, Volmax)
<input type="checkbox"/>	alendronate (Fosamax)
<input type="checkbox"/>	allopurinol (Aloprim, Lopurin, Zyloprim)
<input type="checkbox"/>	alprazolam (Niravam, Xanax)
<input type="checkbox"/>	amlodipine (Norvasc)
<input type="checkbox"/>	atenolol (Senormin, Tenormin)
<input type="checkbox"/>	atorvastatin (Lipitor)
<input type="checkbox"/>	benazepril (Lotensin)
<input type="checkbox"/>	bupropion (Budeprion, Wellbutrin, Zyban)
<input type="checkbox"/>	calcium acetate (Calphron, PhosLo)
<input type="checkbox"/>	carbidopa-levodopa (Atamet, Sinemet)
<input type="checkbox"/>	carvedilol (Coreg, Carvedilol)
<input type="checkbox"/>	celecoxib (Celebrex)
<input type="checkbox"/>	cetirizine (Zyrtec)
<input type="checkbox"/>	citalopram (Celexa)
<input type="checkbox"/>	clonazepam (Klonopin)
<input type="checkbox"/>	clopidogrel (Plavix)

Currently Taking	Medication Name
<input type="checkbox"/>	conjugate estrogens (Cenestin, Premarin)
<input type="checkbox"/>	cyanocobalamin (Neuroforte-R, Vitamin B12)
<input type="checkbox"/>	digoxin (Digitek, Lanoxin)
<input type="checkbox"/>	diltiazem (Cardizem, Tiazac)
<input type="checkbox"/>	donepezil (Aricept)
<input type="checkbox"/>	duloxetine (Cymbalta)
<input type="checkbox"/>	enalapril (Vasotec)
<input type="checkbox"/>	ergocalciferol (Calciferol, Disdol, Vitamin D)
<input type="checkbox"/>	escitalopram (Lexapro)
<input type="checkbox"/>	esomeprazole (Nexium)
<input type="checkbox"/>	estradiol (Estrace, Estrogel, Fempatch)
<input type="checkbox"/>	ezetimibe (Zetia)
<input type="checkbox"/>	ferrous sulfate (FeroSul, Iron Supplement)
<input type="checkbox"/>	fexofenadine (Allegra)
<input type="checkbox"/>	finasteride (Propecia, Proscar)
<input type="checkbox"/>	fluoxetine (Prozac)
<input type="checkbox"/>	fluticasone (Flovent)
<input type="checkbox"/>	fluticasone nasal (Flonase, Veramyst)

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_

Currently Taking	Medication Name
<input type="checkbox"/>	fluticasone-salmeterol (Advair)
<input type="checkbox"/>	furosemide (Lasix)
<input type="checkbox"/>	gabapentin (Neurontin)
<input type="checkbox"/>	galantamine (Razadyne, Reminyl)
<input type="checkbox"/>	glipizide (Glucotrol)
<input type="checkbox"/>	hydrochlorothiazide (Esidrix, Hydrodiuril)
<input type="checkbox"/>	hydrochlorothiazide-triamterene (Dyazide)
<input type="checkbox"/>	latanoprost ophthalmic (Xalatan)
<input type="checkbox"/>	levothyroxine (Levothroid, Levoxyl, Synthroid)
<input type="checkbox"/>	lisinopril (Prinivil, Zestril)
<input type="checkbox"/>	lorazepam (Ativan)
<input type="checkbox"/>	losartan (Cozaar)
<input type="checkbox"/>	lovastatin (Altacor, Mevacor)
<input type="checkbox"/>	meloxicam (Meloxicam, Mobic)
<input type="checkbox"/>	memantine (Namenda)
<input type="checkbox"/>	metformin (Glucophage, Riomet)
<input type="checkbox"/>	metoprolol (Lopressor, Toprol-XL)
<input type="checkbox"/>	mirtazapine (Remeron)
<input type="checkbox"/>	montelukast (Singulair)
<input type="checkbox"/>	naproxen (Aleve, Anaprox, Naprosyn)
<input type="checkbox"/>	niacin (Niacor, Nico-400, Nicotinic Acid)
<input type="checkbox"/>	nifedipine (Adalat, Procardia)
<input type="checkbox"/>	nitroglycerin (Nitro-Bid, Nitro-Dur, Nitrostat)

Currently Taking	Medication Name
<input type="checkbox"/>	omega-3 polyunsaturated fatty acids (Omacor, Lovaza)
<input type="checkbox"/>	omeprazole (Prilosec)
<input type="checkbox"/>	oxybutynin (Ditropan, Urotrol)
<input type="checkbox"/>	pantoprazole (Protonix)
<input type="checkbox"/>	paroxetine (Paxil, Paxil CR, Pexeva)
<input type="checkbox"/>	potassium chloride (K-Dur 10, K-Lor, Slow-K)
<input type="checkbox"/>	pravastatin (Pravachol)
<input type="checkbox"/>	quetiapine (Seroquel)
<input type="checkbox"/>	ranitidine (Zantac)
<input type="checkbox"/>	rivastigmine (Exelon)
<input type="checkbox"/>	rosuvastatin (Crestor)
<input type="checkbox"/>	sertraline (Zoloft)
<input type="checkbox"/>	simvastatin (Zocor)
<input type="checkbox"/>	tamsulosin (Flomax)
<input type="checkbox"/>	terazosin (Hytrin)
<input type="checkbox"/>	tramadol (Ryzolt, Ultram)
<input type="checkbox"/>	trazodone (Desyrel)
<input type="checkbox"/>	valsartan (Diovan)
<input type="checkbox"/>	venlafaxine (Effexor)
<input type="checkbox"/>	warfarin (Coumadin, Jantoven)
<input type="checkbox"/>	zolpidem (Ambien)
<input type="checkbox"/>	Other (specify): _____ _____

## MarkVCID2 CRF Package: Follow-Up Visit

**Patient ID:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

<b>Criteria for Cognitive Diagnoses</b>	
<b>Normal cognition:</b>	<p>Participant has normal cognition and does not have behavioral or language issues sufficient to diagnose MCI or dementia due to FTD or DLB.</p> <p>Normal cognition is defined as:</p> <ol style="list-style-type: none"> <li>1.) No diagnosis of SCD, MCI, or dementia; AND</li> <li>2.) CDR: Sum of Boxes = 0 AND neuropsychological testing within normal range.</li> </ol>
<b>SCD, confirmed diagnosis:</b>	<p>Select if the participant has:</p> <ol style="list-style-type: none"> <li>1.) Cognitive concerns based on a Short ECog-12 score <math>\geq 3</math> on any single item-level response (based on administration to participant), AND</li> <li>2.) Normal cognitive testing (neuropsychological testing within normal range)</li> </ol>
<b>MCI:</b>	<p>Review the criteria listed below to determine whether the subject meets the clinical and cognitive criteria for MCI:</p> <ul style="list-style-type: none"> <li>• Is there a cognitive concern?, i.e., is the subject, the co-participant, or a clinician concerned about a change in cognition compared to the subject's previous level?</li> <li>• Is there impairment in one or more cognitive domains (memory, language, executive function, attention, and visuospatial skills) that is greater than would be expected for the patient's age and educational background?</li> <li>• Is there largely preserved independence in functional abilities (no change from prior level of functioning or requires only extra effort minimal aids or assistance)?</li> <li>• Is there no evidence of dementia (cognitive changes are mild and there is no evidence of a significant impairment in social or occupational functioning)?</li> </ul>
<b>Dementia:</b>	<p>Review the criteria listed below to determine whether the subject meets the criteria for all-cause dementia. These criteria are modified from the McKhann all-cause dementia criteria (2011) to allow a single domain to be affected.</p> <p>The subject has cognitive or behavioral (neuropsychiatric) symptoms that meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>• Interfere with ability to function as before at work or at usual activities?</li> <li>• Represent a decline from previous levels of functioning?</li> <li>• Are not explained by delirium or major psychiatric disorder?</li> <li>• Include cognitive impairment detected and diagnosed through a combination of 1) history-taking and 2) objective cognitive assessment (bedside or neuropsychological testing)?</li> </ul> <p><b>AND</b></p> <p>Impairment in one* or more of the following domains.</p> <ul style="list-style-type: none"> <li>– Impaired ability to acquire and remember new information</li> <li>– Impaired reasoning and handling of complex tasks, poor judgment</li> <li>– Impaired visuospatial abilities</li> <li>– Impaired language functions</li> <li>– Changes in personality, behavior, or comporment</li> </ul> <p>* In the event of single-domain impairment (e.g., language in PPA, behavior in bvFTD, posterior cortical atrophy), the subject must not fulfill criteria for MCI.</p> <p>Select if the participant:</p> <ol style="list-style-type: none"> <li>1.) Meets the criteria for dementia, AND</li> <li>2.) CDR: Global Score = 0.5 or 1</li> </ol>