



National Institutes of Health

National Institute of Neurological Disorders and Stroke
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

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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

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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 since the last study visit :	<input type="checkbox"/> 1 cigarette to less than ½ pack	<input type="checkbox"/> ½ pack to less than 1 pack
	<input type="checkbox"/> 1 pack to less than 1½ packs	<input type="checkbox"/> 1½ packs to less than 2 packs
	<input type="checkbox"/> 2 packs or more	<input type="checkbox"/> Unknown

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.*

	No	Yes	Not Assessed
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"/>

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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		

*For the following three questions, ask whether the subject has been diagnosed with any **new** cardiovascular disease **since the last study visit** other than those listed above.*

For other cardiovascular disease, enter 'N/A' if absent	No	Yes	Not Assessed
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

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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

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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
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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"/>
---	--------------------------	--------------------------	--------------------------

*Select **Yes** if there are biological parents, full siblings, or biological children who have a history of symptomatic stroke and/or TIA with clear ischemic mechanism*

If yes:

1a. Any cases with onset before age 55?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	--------------------------

1b. Is there a pattern suggestive of an autosomal dominant family history?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------

*Select **Yes** 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)*

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"/>
--	--------------------------	--------------------------	--------------------------

*Select **Yes** if there are biological parents, full siblings, or biological children who are affected by dementia, Alzheimer's disease, or have history of cognitive impairment*

If yes:

2a. Any report of a case in the family with autopsy confirmation of Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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2b. Any report of cases with autopsy confirmation of another cause of dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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"/>
--	--------------------------	--------------------------	--------------------------

*Select **Yes** 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)*

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

3a. Is there a known mutation? <input type="checkbox"/> No <input type="checkbox"/> Yes

3b. If yes, please indicate which one: <input type="checkbox"/> PSEN1 <input type="checkbox"/> APP <input type="checkbox"/> PSEN2 <input type="checkbox"/> CADASIL <input type="checkbox"/> Other, specify gene if known: _____
--

Specify mutation if known: _____

*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 **Other** and specify the gene.*

3c. Does this individual carry the mutation? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
--

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Patient ID: _ _ _ _ _

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**.

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

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

CEREBROVASCULAR FEATURES

Were neurological signs considered by examiner to be most likely consistent with cerebrovascular disease present? No Yes

*If any of the signs consistent with CVD below are present, select **Yes**; otherwise, select **No** and skip to **Other Findings** section.*

Cortical cognitive deficit (e.g., aphasia, apraxia, neglect)

Lateralized motor weakness: indicate as present if it is suspected that there is acquired proximal or distal extremity weakness attributable to cerebrovascular ischemia.

Lateralized abnormal reflexes (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.

Cortical visual field loss: involves homonymous hemianopsia or quadrantanopsia, or cortical blindness, excluding visual field loss due to optic nerve disease or injury.

Somatosensory loss: 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: LEFT SIDE OF BODY	No	Yes	Not Assessed
2. Lateralized motor weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cortical visual field loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Somatosensory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Findings consistent with stroke / cerebrovascular disease: RIGHT SIDE OF BODY	No	Yes	Not Assessed
6. Lateralized motor weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cortical visual field loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Somatosensory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER FINDINGS	No	Yes	Not Assessed
1. Patient demonstrates spontaneous, disproportionate or involuntary crying or laughing on examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is magnetic gait apraxia present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Indicate whether gait apraxia characteristic of normal-pressure hydrocephalus or bilateral subcortical ischemia is present by selecting Yes. 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"/>

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Patient ID: _ _ _ _ _

COGNITIVE DIAGNOSIS

Evaluated? No Yes

Reason not evaluated: _____

Date of Evaluation: ___ / ___ / _____ (MM/DD/YYYY)

SYNDROMIC DIAGNOSIS
(see page 40 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

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RELATED DIAGNOSES (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"/>
OTHER DIAGNOSES	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"/>

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NEUROPSYCHOLOGICAL TESTING BATTERY

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

Was any part of the Neuropsychological Testing Battery 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)

Language of test administration: English Spanish
 Other (specify): _____

Indicate the primary language used when administering the remainder of the tests.

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

94 = Test not administered as part of battery at this session (where applicable)

95 = Physical problem

96 = Cognitive/behavior problem

97 = Other problem

98 = Verbal refusal (not for any of the reasons 94-97)

Scores for item 1 correspond to the Craft Store 21 Recall (Immediate) Worksheets

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]

Method of Administration: In-person Video Phone

Scores for item 2 correspond to the Craft Store 21 Recall (Delayed) Worksheets

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

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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] AVLT

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: _ _ _ _ _

<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					
Section 2: Supplemental CDR					
<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: _ _ _ _ _

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: _ _ _ _ _

FUNCTIONAL ASSESSMENT SCALE (FAS)

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

Was the FAS 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): _____

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

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: _____

LACUNES AND MICROBLEEDS

Was the scan assessed for lacunes and microbleeds? No Yes

Initials of lacune and microbleed assessor: _____

Does the participant have ≥ 1 lacune? No Yes

If ≥ 1 lacune, please select all the regions where lacunes are present:

Deep: ≤ 2 > 2

Lobar: ≤ 2 > 2

Does the participant have ≥ 1 microbleed? No Yes

If ≥ 1 microbleed, please select all the regions where microbleeds are present:

Lobar (supratentorial): ≤ 4 > 4

Deep (supratentorial): ≤ 4 > 4

Cerebellar (cortical): ≤ 4 > 4

Cerebellar (deep): ≤ 4 > 4

Brainstem: ≤ 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: _____

BRAIN DONATION CONSENT

Have study staff approached participant OR next of kin in life to discuss brain donation? No Yes

(Note: State law dictates whether sites may receive traditional consent at the time of death by next of kin OR receive consent during the participant's life)

If no, reason not approached: _____

Date approached: ____ / ____ / ____ (MM/DD/YYYY)

IF APPROACHED

Was consent or indication of intent for brain donation received?

- No (participant or next of kin declined brain donation)
- Yes (participant or next of kin consented or indicated intent for brain donation)
- Information regarding brain donation was provided, but no conclusion was reached

If consent or indication of intent for brain donation consent received, was it received through a co-enrolled study? No Yes

If yes, name of study: _____

MarkVCID2 CRF Package: Follow-Up Visit

Patient ID: _ _ _ _ _

Criteria for Cognitive Diagnoses	
Normal cognition:	<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"> 1.) No diagnosis of SCD, MCI, or dementia; AND 2.) CDR: Sum of Boxes = 0 AND neuropsychological testing within normal range.
SCD, confirmed diagnosis:	<p>Select if the participant has:</p> <ol style="list-style-type: none"> 1.) Cognitive concerns based on a Short ECog-12 score ≥ 3 on any single item-level response (based on administration to participant), AND 2.) Normal cognitive testing (neuropsychological testing within normal range)
MCI:	<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"> • 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? • 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? • Is there largely preserved independence in functional abilities (no change from prior level of functioning or requires only extra effort minimal aids or assistance)? • Is there no evidence of dementia (cognitive changes are mild and there is no evidence of a significant impairment in social or occupational functioning)?
Dementia:	<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"> • Interfere with ability to function as before at work or at usual activities? • Represent a decline from previous levels of functioning? • Are not explained by delirium or major psychiatric disorder? • Include cognitive impairment detected and diagnosed through a combination of 1) history-taking and 2) objective cognitive assessment (bedside or neuropsychological testing)? <p>AND</p> <p>Impairment in one* or more of the following domains.</p> <ul style="list-style-type: none"> - Impaired ability to acquire and remember new information - Impaired reasoning and handling of complex tasks, poor judgment - Impaired visuospatial abilities - Impaired language functions - Changes in personality, behavior, or comporment <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"> 1.) Meets the criteria for dementia, AND 2.) CDR: Global Score = 0.5 or 1