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

Contents

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

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

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	☐	☐	☐
If yes, more than one heart attack?	☐	☐	☐

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	☐	☐	☐
Angioplasty/ endarterectomy/ stent	☐	☐	☐
Cardiac bypass procedure	☐	☐	☐
Pacemaker and/or defibrillator	☐	☐	☐
Congestive heart failure	☐	☐	☐
Angina	☐	☐	☐

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

NEW CARDIOVASCULAR DISEASE DIAGNOSED SINCE MOST RECENT STUDY VISIT (cont.)			
If yes:	**No**	**Yes**	**Not Assessed**
Heart valve replacement or repair	☐	☐	☐
Type of replacement/repair (select all that apply):	☐ Mitral ☐ Aortic ☐ Unknown ☐ Other (specify): _____		
Type of replacement (select all that apply):	☐ Bioprosthetic ☐ Mechanical ☐ Unknown ☐ 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): _____ _____	☐	☐	☐
Other cardiovascular disease (specify): _____ _____	☐	☐	☐
Other cardiovascular disease (specify): _____ _____	☐	☐	☐

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	__ __ ☐Unknown	☐ Ischemic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism ☐ Hemorrhagic	☐ No ☐ Yes ☐ Unknown
Stroke/Acute Vascular Event 2	__ __ ☐Unknown	☐ Ischemic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism ☐ Hemorrhagic	☐ No ☐ Yes ☐ Unknown
Stroke/Acute Vascular Event 3	__ __ ☐Unknown	☐ Ischemic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism ☐ Hemorrhagic	☐ No ☐ Yes ☐ Unknown
Stroke/Acute Vascular Event 4	__ __ ☐Unknown	☐ Ischemic ☐ Stroke type unknown ☐ TIA with clear ischemic mechanism ☐ Hemorrhagic	☐ No ☐ Yes ☐ Unknown

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	☐	☐	☐
Pseudobulbar affect (i.e., crying or laughing that appears involuntary and out-of-proportion to the situation)	☐	☐	☐
Seizures	☐	☐	☐
Traumatic brain injury (TBI)	☐	☐	☐

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	☐	☐	☐
If recent/active or remote/inactive, which type?	☐ Type 1 ☐ Type 2 ☐ Other type (latent autoimmune diabetes/ type 1.5, gestational diabetes) ☐ Unknown		
Diagnosis of hypertension	☐	☐	☐
Is hypertension treated? ☐ No ☐ Yes			

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

NEW MEDICAL CONDITIONS DIAGNOSED SINCE MOST RECENT STUDY VISIT (continued)			
Condition	**No**	**Yes**	**Not Assessed**
Hypercholesterolemia	☐	☐	☐
B12 deficiency	☐	☐	☐
Thyroid disease	☐	☐	☐
Arthritis	☐	☐	☐
Type of arthritis: ☐ Rheumatoid ☐ Osteoarthritis ☐ Other (specify): _____ ☐ Unknown			
*If subject has both rheumatoid arthritis and osteoarthritis, select **Rheumatoid**.*			
Region(s) affected (check all that apply): ☐ Upper extremity ☐ Lower extremity ☐ Spine ☐ Unknown			
Incontinence – urinary	☐	☐	☐
Incontinence – bowel	☐	☐	☐
Sleep apnea	☐	☐	☐
REM sleep behavior disorder (RBD)	☐	☐	☐
Hyposomnia/insomnia	☐	☐	☐

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?	☐	☐	☐
*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?	☐	☐	☐
1b. Is there a pattern suggestive of an autosomal dominant family history?	☐	☐	☐
*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?	☐	☐	☐
*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?	☐	☐	☐
2b. Any report of cases with autopsy confirmation of another cause of dementia?	☐	☐	☐
2c. Any cases with onset before age 65?	☐	☐	☐
2d. Is there a pattern suggestive of an autosomal dominant family history?	☐	☐	☐
*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? ☐ No ☐ Yes

3b. If yes, please indicate which one: ☐ PSEN1 ☐ APP ☐ PSEN2 ☐ CADASIL
☐ 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? ☐ No ☐ Yes ☐ Unknown

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]

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

GAIT SPEED TEST DETAILS	
Length of walk test course:	☐ 4 meters ☐ 3 meters
FIRST GAIT SPEED TEST	
First gait speed test completed:	☐ No ☐ Yes
Time for first gait speed test:	__ __.__ __ seconds
If participant did not attempt first test or failed:	☐ Tried but unable ☐ Participant could not walk unassisted ☐ Not attempted, you felt unsafe ☐ Not attempted, participant felt unsafe ☐ Participant unable to understand instructions ☐ Participant refused ☐ Other (specify): _____
Aids for first walk:	☐ None ☐ Cane ☐ Unknown ☐ Other (specify): _____
SECOND GAIT SPEED TEST	
Second gait speed test completed:	☐ No ☐ Yes
Time for second gait speed test:	__ __.__ __ seconds
If participant did not attempt second test or failed:	☐ Tried but unable ☐ Participant could not walk unassisted ☐ Not attempted, you felt unsafe ☐ Not attempted, participant felt unsafe ☐ Participant unable to understand instructions ☐ Participant refused ☐ Other (specify): _____
Aids for second walk:	☐ None ☐ Cane ☐ Unknown ☐ Other (specify): _____

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.***

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

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

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)	☐	☐	☐
Findings consistent with stroke / cerebrovascular disease: **LEFT SIDE OF BODY**	No	Yes	Not Assessed
2. Lateralized motor weakness	☐	☐	☐
3. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	☐	☐	☐
4. Cortical visual field loss	☐	☐	☐
5. Somatosensory loss	☐	☐	☐

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

Findings consistent with stroke / cerebrovascular disease: **RIGHT SIDE OF BODY**	No	Yes	Not Assessed
6. Lateralized motor weakness	☐	☐	☐
7. Lateralized abnormal reflexes (to include pathologically brisk deep tendon reflexes, Babinski signs, others)	☐	☐	☐
8. Cortical visual field loss	☐	☐	☐
9. Somatosensory loss	☐	☐	☐
OTHER FINDINGS	No	Yes	Not Assessed
1. Patient demonstrates spontaneous, disproportionate or involuntary crying or laughing on examination	☐	☐	☐
2. Is magnetic gait apraxia present?	☐	☐	☐
*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.*			
3. Higher cortical visual problem suggesting posterior cortical atrophy (e.g., prosopagnosia, simultagnosia, Balint's syndrome) or apraxia of gaze	☐	☐	☐
4. Findings suggestive of progressive supranuclear palsy (PSP), corticobasal syndrome (CBS), or other related disorders	☐	☐	☐
5. Findings suggesting ALS (e.g., muscle wasting, fasciculations, upper motor neuron and/or lower motor neuron signs)	☐	☐	☐

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

COGNITIVE DIAGNOSIS

Evaluated? ☐ No ☐ Yes

Reason not evaluated: _____

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

SYNDROMIC DIAGNOSIS *(see page 41 for diagnostic criteria)*
☐ Normal Cognition ☐ Subjective cognitive decline (SCD)
☐ Mild cognitive impairment (MCI) ☐ Dementia

Age of Onset of SCD, MCI, or 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	☐	☐	☐	☐
Vascular brain injury (based on clinical or imaging evidence)	☐	☐	☐	☐
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)	☐	☐	☐	☐
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	☐	☐	☐	☐
If present: ☐ Mild/well-controlled ☐ Severe/incompletely controlled*				
Alcohol abuse	☐	☐	☐	☐
If present: Current alcohol abuse ☐ No ☐ Yes* ☐ Unknown				
Hydrocephalus	☐	☐	☐	☐
CNS neoplasm	☐	☐	☐	☐
If present: ☐ Benign ☐ Malignant*				
Delirium	☐	☐	☐	☐
Post-traumatic stress disorder (PTSD)	☐	☐	☐	☐

*Diagnosis at this severity excluded at baseline; may appear at follow-up visit

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

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

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]

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]

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]

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]

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

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

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]

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 site's specific scoring instructions for the CVLT, CVLT-SF, HVLT, AVLT/RAVLT, CERAD, or SEVLT., or other with list learning with immediate/delay/recognition.
*For MarkVCID participants co-enrolled in an ADRC, sites are encouraged to conduct either AVLT/RAVLT or CERAD list-learning task with co-enrolled participants as required by the NACC's 2025 Uniform Data Set 4.0 updates. For participants **not** co-enrolled in an ADRC, sites are welcome to continue using their current list-learning task.*

10. Word list learning with immediate/delay/recognition:
   a) Name of test: ☐ HVLT ☐ CVLT ☐ CVLT-SF
   ☐ SEVLT [Spanish] ☐ SEVLT [English] ☐ AVLT/RAVLT ☐ CERAD
   ☐ 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

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]

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

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 the primary reason: ☐ Physical problem ☐ Cognitive/behavior problem ☐ 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)

Patient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Please enter score below:	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 *(auto-calculated in EDC)*					
8. ___ ___ STANDARD GLOBAL CDR					

Section 2: Supplemental CDR

Please enter score below:	IMPAIRMENT				
	None – 0	Questionable – 0.5	Mild – 1	Moderate – 2	Severe – 3
9. Behavior, comportment, and personality ___ . ___	Socially appropriate behavior	Questionable changes in comportment, empathy, appropriateness of actions	Mild but definite changes in behavior	Moderate behavioral changes, affecting interpersonal relationships and interactions in a significant manner	Severe behavioral changes, making interpersonal interactions all unidirectional
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

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?	☐	☐	☐
2. Have you dropped many of your activities and interests?	☐	☐	☐
3. Do you feel that your life is empty?	☐	☐	☐
4. Do you often get bored?	☐	☐	☐
5. Are you in good spirits most of the time?	☐	☐	☐
6. Are you afraid that something bad is going to happen to you?	☐	☐	☐
7. Do you feel happy most of the time?	☐	☐	☐
8. Do you often feel helpless?	☐	☐	☐
9. Do you prefer to stay at home, rather than going out and doing new things?	☐	☐	☐
10. Do you feel you have more problems with memory than most people?	☐	☐	☐
11. Do you think it is wonderful to be alive?	☐	☐	☐
12. Do you feel pretty worthless the way you are now?	☐	☐	☐
13. Do you feel full of energy?	☐	☐	☐
14. Do you feel that your situation is hopeless?	☐	☐	☐
15. Do you think that most people are better off than you are?	☐	☐	☐

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

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)?	☐	☐	☐	☐	☐
2. Remember the current date or day of the week?	☐	☐	☐	☐	☐
3. Communicate thoughts in a conversation?	☐	☐	☐	☐	☐
4. Understand spoken directions or instructions?	☐	☐	☐	☐	☐
5. Read a map and help with directions when someone else is driving?	☐	☐	☐	☐	☐
6. Find one's way around a house/building that you have visited many times?	☐	☐	☐	☐	☐
7. Anticipate weather changes and planning accordingly?	☐	☐	☐	☐	☐
8. Think ahead?	☐	☐	☐	☐	☐
9. Keep your living and workspace organized?	☐	☐	☐	☐	☐
10. Balance your checkbook/ account without error?	☐	☐	☐	☐	☐
11. Do two things at once?	☐	☐	☐	☐	☐
12. Cook or work, and talk at the same time?	☐	☐	☐	☐	☐

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)

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)?	☐	☐	☐	☐	☐
2. Remember the current date or day of the week?	☐	☐	☐	☐	☐
3. Communicate thoughts in a conversation?	☐	☐	☐	☐	☐
4. Understand spoken directions or instructions?	☐	☐	☐	☐	☐
5. Read a map and help with directions when someone else is driving?	☐	☐	☐	☐	☐
6. Find their way around a house/building that you have visited many times?	☐	☐	☐	☐	☐
7. Anticipate weather changes and planning accordingly?	☐	☐	☐	☐	☐
8. Think ahead?	☐	☐	☐	☐	☐
9. Keep their living and workspace organized?	☐	☐	☐	☐	☐
10. Balance their checkbook/ account without error?	☐	☐	☐	☐	☐
11. Do two things at once?	☐	☐	☐	☐	☐
12. Cook or work, and talk at the same time?	☐	☐	☐	☐	☐

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)

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?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐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?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown
3. Agitation/aggression — Is the patient resistive to help from others at times, or hard to handle?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown
4. Depression/dysphoria — Does the patient seem sad or say that he/she is depressed?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐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?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown
6. Elation/euphoria — Does the patient appear to feel too good or act excessively happy?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown
7. Apathy/ indifference — Does the patient seem less interested in his/her usual activities or in the activities and plans of others?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown

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?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown
9. Irritability/lability — Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐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?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐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?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown
12. Appetite/eating — Has the patient lost or gained weight, or had a change in the type of food he/she likes?	☐	☐	☐	☐Mild ☐Moderate ☐Severe ☐Unknown

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	☐	☐	☐	☐	☐	☐
2. Assembling tax records, business affairs, or other papers	☐	☐	☐	☐	☐	☐
3. Shopping alone for clothes, household necessities, or groceries	☐	☐	☐	☐	☐	☐
4. Playing a game of skill such as bridge or chess, working on a hobby	☐	☐	☐	☐	☐	☐
5. Heating water, making a cup of coffee, turning off the stove	☐	☐	☐	☐	☐	☐
6. Preparing a balanced meal	☐	☐	☐	☐	☐	☐
7. Keeping track of current events	☐	☐	☐	☐	☐	☐
8. Paying attention to and understanding a TV program, book, or magazine	☐	☐	☐	☐	☐	☐
9. Remembering appointments, family occasions, holidays, medications	☐	☐	☐	☐	☐	☐
10. Traveling out of the neighborhood, driving, or arranging to take public transportation	☐	☐	☐	☐	☐	☐

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
☐	1. HS-CRP	__ __ / __ __ / __ __ __ __	N/A	__ __ __	☐ nmol/L ☐ g/L ☐ mg/L
☐	2. HbA1c*	__ __ / __ __ / __ __ __ __	N/A	__ __ __	☐ mmol/mol ☐ %
☐	3. Blood Sugar	__ __ / __ __ / __ __ __ __	☐ Fasting >8 hours ☐ Not fasting	__ __ __	☐ mmol/L ☐ mg/dL ☐ mg/L
☐	4. Serum cholesterol*	__ __ / __ __ / __ __ __ __	☐ Fasting >8 hours ☐ Not fasting	__ __ __	☐ mg/dL ☐ mmol/L
☐	5. HDL cholesterol*	__ __ / __ __ / __ __ __ __	☐ Fasting >8 hours ☐ Not fasting	__ __ __	☐ mg/dL ☐ mmol/L
☐	6. LDL cholesterol*	__ __ / __ __ / __ __ __ __	☐ Fasting >8 hours ☐ Not fasting	__ __ __	☐ mg/dL ☐ mmol/L
☐	7. Triglycerides*	__ __ / __ __ / __ __ __ __	☐ Fasting >8 hours ☐ Not fasting	__ __ __	☐ mg/dL ☐ mmol/L
☐	8. Homocysteine	__ __ / __ __ / __ __ __ __	☐ Fasting >8 hours ☐ Not fasting	__ __ __	☐ mg/dL ☐ umol/L ☐ mg/L
☐	9. Serum creatinine*	__ __ / __ __ / __ __ __ __	N/A	__ __ __	☐ mg/dL ☐ umol/L
☐	10. Serum cystatin C	__ __ / __ __ / __ __ __ __	N/A	__ __ __	☐ mg/L ☐ 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

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 -80º 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):_____

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 -80º 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):_____

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:	☐ Grade 0 – No lesions ☐ Grade 1 – Caps or pencil-thin lining ☐ Grade 2 – Smooth haloing ☐ Grade 3 – Irregular WMH extending into DWM ☐ Unknown/ N/A
Deep Fazekas Extent Grade:	☐ Grade 0 – No lesions ☐ Grade 1 – Punctate lesions ☐ Grade 2 – Beginning confluent lesions ☐ Grade 3 – Confluent lesions ☐ Unknown/ N/A
Deep Fazekas Lesion Count Grade:	☐ Grade 0 – No lesions ☐ Grade 1 – 1-4 lesions ☐ Grade 2 – 5-9 lesions ☐ Grade 3 – >9 lesions ☐ Unknown/ N/A
Overall Fazekas Score : _____ *(Maximum score of Peri-Ventricular Fazekas Extent Grade and Deep Fazekas Extent Grade)*	

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

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

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

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

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

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

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: _____	

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

CONSENT FOR FUTURE CONTACT
Has the participant consented to being contacted after the study for future research? ☐ Yes ☐ Not yet discussed with participant ☐ No (declined)
If declined, reason: _____ _____
Has the informant agreed to being contacted after the study for future research? ☐ Yes ☐ Not yet discussed with informant ☐ Not applicable ☐ No

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

Criteria for Cognitive Diagnoses	
Normal cognition:	Participant has normal cognition and does not have behavioral or language issues sufficient to diagnose MCI or dementia due to FTD or DLB. Normal cognition is defined as: 1.) No diagnosis of SCD, MCI, or dementia; AND 2.) CDR: Sum of Boxes = 0 AND neuropsychological testing within normal range.
SCD, confirmed diagnosis:	Select if the participant has: 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:	Review the criteria listed below to determine whether the subject meets the clinical and cognitive criteria for MCI: • 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:	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. The subject has cognitive or behavioral (neuropsychiatric) symptoms that meet all of the following criteria: • 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)? **AND** Impairment in one* or more of the following domains. – 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 comportment * 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.