

INITIAL VISIT PACKET NACC UNIFORM DATA SET (UDS) **DOWN SYNDROME MODULE**

Form D1D: Clinician Exam and Diagnosis

ADC name: _____ Subject ID: _____ Form date: ____ / ____ / _____

Visit #: _____ Examiner's initials: _____

INSTRUCTIONS: This form is to be completed by the clinician. For additional clarification and examples, see Down Syndrome Coding Guidebook for Initial Visit Packet, Form D1D. Check only one box per question.

1. Head circumference	____ ____ ____ cm (888 = Not assessed)
2. Pathological reflexes — grasp	<input type="checkbox"/> 1 Absent <input type="checkbox"/> 2 Present <input type="checkbox"/> 9 Unknown/not assessed
3. Pathological reflexes — snout	<input type="checkbox"/> 1 Absent <input type="checkbox"/> 2 Present <input type="checkbox"/> 9 Unknown/not assessed
4. Pathological reflexes — rooting	<input type="checkbox"/> 1 Absent <input type="checkbox"/> 2 Present <input type="checkbox"/> 9 Unknown/not assessed
5. What is the participant's chromosome diagnosis?	<input type="checkbox"/> 1 Trisomy 21 <input type="checkbox"/> 2 Translocation DS <input type="checkbox"/> 3 Mosaic DS <input type="checkbox"/> 9 Unknown/not assessed
6. What is the participant's cognitive status?	<input type="checkbox"/> 1 Cognitively stable <input type="checkbox"/> 2 MCI-DS <input type="checkbox"/> 3 Dementia <input type="checkbox"/> 9 Unable to determine