

**INITIAL VISIT PACKET** NACC UNIFORM DATA SET (UDS) — FTLD MODULE

# Form E3F: Imaging in Diagnosis

Center: \_\_\_\_\_ Subject ID: \_\_\_\_\_ Form Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NOTE: This form is to be completed by the clinician or imaging specialist involved in interpreting the scan. For additional clarification and examples, see FTLD Module Coding Guidebook for Initial Visit Packet, Form E3F. Check only one box per question.**

Visit #: \_\_\_\_\_  
 Examiner's initials: \_\_\_\_\_

	No	Yes	Unknown
<b>1. Was imaging obtained as part of this visit for use in diagnosis?</b> If the answer is "0 (No)", SKIP THE REST OF THIS FORM.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
<b>STRUCTURAL MRI</b>			
<b>2. Was structural MRI done?</b> If "No", SKIP TO QUESTION 3.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
<b>2a. Was focal atrophy (beyond what would be expected for age) appreciated by visual inspection?</b> If "No" or "Unknown", SKIP TO QUESTION 3.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
<b>Where was focal atrophy appreciated?</b>			
2a1. Right frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a2. Left frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a3. Right temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a4. Left temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a5. Right medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a6. Left medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a7. Right parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a8. Left parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a9. Right basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a10. Left basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2a11. Other area of the brain (specify below): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9

	No	Yes	Unknown
<b>FDG-PET</b>			
<b>3. Was FDG-PET done?</b> If "No", SKIP TO QUESTION 4.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
<b>3a. Was focal hypometabolism appreciated by visual inspection?</b> If "No" or "Unknown", SKIP TO QUESTION 4.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
<b>Where was focal hypometabolism appreciated?</b>			
3a1. Right frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a2. Left frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a3. Right temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a4. Left temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a5. Right medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a6. Left medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a7. Right parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a8. Left parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a9. Right basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a10. Left basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3a11. Other area of the brain (specify below): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9

	No	Yes	Unknown
<b>AMYLOID PET</b>			
<b>4. Was amyloid PET done?</b> If "No", SKIP TO QUESTION 5.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
<b>4a. Was amyloid deposition appreciated by visual inspection?</b> If "No" or "Unknown", SKIP TO QUESTION 5.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
<b>Where was amyloid deposition noted?</b>			
4a1. Right frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a2. Left frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a3. Right temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a4. Left temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a5. Right medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a6. Left medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a7. Right parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a8. Left parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a9. Right basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a10. Left basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4a11. Other area of the brain (specify below): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9

	No	Yes	Unknown
<b>CBF SPECT</b>			
<b>5. Was CBF SPECT done?</b> If "No", SKIP TO QUESTION 6.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
<b>5a. Were abnormalities appreciated by visual inspection?</b> If "No" or "Unknown", SKIP TO QUESTION 6.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
<b>Where were abnormalities noted?</b>			
5a1. Right frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a2. Left frontal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a3. Right temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a4. Left temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a5. Right medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a6. Left medial temporal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a7. Right parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a8. Left parietal lobe	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a9. Right basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a10. Left basal ganglia	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5a11. Other area of the brain (specify below): _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9

	No	Yes	Unknown
<b>OTHER IMAGING</b>			
<b>6. Was other imaging done?</b>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	
<b>If yes, specify:</b> _____			