

**FOLLOW-UP VISIT PACKET** NACC UNIFORM DATA SET (UDS) **FTLD MODULE**

## Form E3F: Imaging in Diagnosis

ADC name: \_\_\_\_\_ Subject ID: \_\_\_\_\_ Form date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

	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

	No	Yes	Unknown
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> If "Yes", specify: _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	