

**INITIAL VISIT PACKET** NACC UNIFORM DATA SET (UDS) **LBD MODULE V3.1 SHORT VERSION**

# Form B5L: Mayo Fluctuations Scale

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

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

*INSTRUCTIONS: This form is to be completed by a clinician or other trained health professional, based on co-participant response. For additional clarification and examples, see LBD Module Coding Guidebook for Initial Visit Packet, Form B5L. Check only one box per question.*

**DIRECTIONS: Please mark the answer that best describes the participant within the past 6 months.**

<p>1. <b>Is the participant drowsy and lethargic during the day, despite getting enough sleep the night before?</b></p>	<p><input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown</p>
<p>2. <b>Does the participant sleep 2 or more hours during the day (before 7:00 p.m.)?</b></p>	<p><input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown</p>
<p>3. <b>Are there times when the participant's flow of ideas is disorganized, unclear, or not logical?</b></p>	<p><input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown</p>
<p>4. <b>Does the participant tend to stare into space for long periods of time?</b></p>	<p><input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 9 Unknown</p>