

# Form Z1X: Form Checklist

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

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

*INSTRUCTIONS: This form is to be completed by clinic personnel.*

NACC expects and intends that all UDS forms will be attempted on all subjects, but we realize this may be impossible when the patient is terminally ill, or when there is no co-participant, or for other reasons. An explanation is required below for forms that are not submitted.

## UDS TELEPHONE VISIT

Form	Language:		Description	Submitted:		If not submitted, specify reason (see KEY):
	English	Spanish		Yes	No	
T1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Inclusion Form	<b>Required</b>		
A1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Subject Demographics	<b>Required</b>		
A2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Co-participant Demographics	<b>Required</b>		
A3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Subject Family History	<input type="checkbox"/> 1	<input type="checkbox"/> 0	— —
A4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Subject Medications	<input type="checkbox"/> 1	<input type="checkbox"/> 0	— —
B4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	CDR® Plus NACC FTLD	<b>Required</b>		
B5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	BEHAVIORAL ASSESSMENT NPI-Q	<input type="checkbox"/> 1	<input type="checkbox"/> 0	— —
B6	<input type="checkbox"/> 1	<input type="checkbox"/> 2	BEHAVIORAL ASSESSMENT GDS	<input type="checkbox"/> 1	<input type="checkbox"/> 0	— —
B7	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FUNCTIONAL ASSESSMENT NACC FAS	<input type="checkbox"/> 1	<input type="checkbox"/> 0	— —
B9	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Clinician Judgment of Symptoms	<b>Required</b>		
C2T	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Neuropsych Battery Scores	<input type="checkbox"/> 1	<input type="checkbox"/> 0	— —
D1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Clinician Diagnosis	<b>Required</b>		
D2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Clinician-assessed Medical Conditions	<b>Required</b>		

## CLS FORM

Form	Language:		Description	Submitted:		
	English	Spanish		Yes	No	
CLS	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Subject's Language History	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<b>Submit only once</b>

**KEY: If the specified form was not completed, please enter one of the following codes:**

- 95=Physical problem**
- 96=Cognitive or behavioral problem**
- 97=Other problem**
- 98=Verbal refusal**