

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

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	Required		
A1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Subject Demographics	Required		
A2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Co-participant Demographics	Required		
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	— —
A5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Subject Health History	Required		
B1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	EVALUATION FORM Physical	Required		
B4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	CDR® Plus NACC FTLD	Required		
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	— —
B8	<input type="checkbox"/> 1	<input type="checkbox"/> 2	EVALUATION FORM Neurological Examination Findings	<input type="checkbox"/> 1	<input type="checkbox"/> 0	— —
B9	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Clinician Judgment of Symptoms	Required		
C2T	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Neuropsychological Battery Scores	Required		
D1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Clinician Diagnosis	Required		
D2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Clinician-assessed Medical Conditions	Required		

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	Submit only once

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**