

WAI Network Data Information Form (7th edition)

1. Clinic name: _____ 2. Year of visit: _____ 3. Length of visit (mins): _____

- 4. Referral source:**
 Self/family member Primary care provider
 ADRC/DCS Alz. Assoc./ADAW
 WAI Milwaukee Other: _____

- 5. Reason for referral:**
 Memory/cognitive changes Behavioral concerns
 Diagnosis 2nd opinion
 Treatment recommendations Family history of dementia
 Safety concerns (i.e., driving) Other: _____

6. Gender: Female Male Other

- 7. Primary race/ethnicity:**
 White Black / African American
 Hispanic/Latino American Indian or Alaska Native
 Asian (e.g. Hmong) Other: _____

8. Does this person speak a language other than English at home? Yes No

- 9. Residence:** Lives alone Assisted living
 Lives with other adult Nursing home Other: _____

9.1 Distance from clinic (miles): ≤25 26-50 51-75 ≥ 76

10. Number of family members/ companions seen in clinic: _____

11. Patient's Age: ≥90 years If under 90, write age: _____

12. Years of education (High school graduate is 12 years): _____

13. Duration of cognitive symptoms (in years): _____

- 14. Cognitive Testing:**
 _____ MMSE Score (0-30) _____ Trails A (time in seconds)
 _____ MoCA Score (0-30) _____ Trails B (time in seconds)
 _____ SLUMS Score (0-30) _____ Animal Fluency (# in 60 sec)
 _____ ACE Mini Score (0-30) _____ Mini-Cog (0-5)

15. Quality Measure 3: Did you identify any impairment to perform basic activities (ADL) or instrumental activities?

Yes No Not evaluated

_____ Lawton IADL Score (0-8) _____ Katz ADL Score (0-6)
 _____ Barthel ADL Index (0-100) _____ Functional Activities Qs (0-30)

16. Sleep/Sleep Apnea: _____ STOP BANG (0-8)
 _____ Epworth Sleepiness Score (0-24)

17. Quality Measure 4: Mood/Behavioral/Psychiatric symptoms

_____ GDS Score (0-15) _____ NPIQ Score (0-90) _____ PHQ-9

18. Any mood, behavioral, or psychiatric symptom(s) identified?

Yes No Not evaluated

↳ **Did you provide management recommendations?**
 Yes No Unknown N/A

19. Quality Measure 5: Safety concern screening and follow up

	Screened		Issue identified		Management Provided			
	Yes	No N/A	Yes	No	Educate	Refer	Rx	N/A*
Medication misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical aggressiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wandering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial mismanagement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home safety (e.g. issues cooking, trip hazards)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to chemicals, firearms, or power tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.Q6 Driving safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.Q7 Advanced care plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*N/A: Not applicable (e.g. Driving -> Pt does not know how to drive)

22. Quality Measure 8: Was the patient screened for pain?

Yes No Unknown

↳ **Did you provide management recommendations?**

Yes No N/A, OR already being treated for pain

23. Suspected Diagnoses:

- Dementia / Major Neurocognitive Disorder
 MCI / Mild Neurocognitive Disorder
 Normal / No cognitive deficit Other: _____

24. Suspected Etiology/Cause associated with diagnosis above
 Mark "1" next to primary diagnosis and "2" next to the secondary diagnosis (mark as many secondary as applicable)

- | | |
|--|------------------------------------|
| _____ Alzheimer's Disease | _____ Mixed dementia (AD/vascular) |
| _____ Alcohol abuse | _____ Parkinson's dementia |
| _____ Depression and/or anxiety disorder | _____ Psychiatric disorder |
| _____ FTD/FTLD | _____ Sleep disorder |
| _____ IDD | _____ TBI/head injury |
| _____ LBD | _____ Undetermined |
| _____ Medication-related | _____ Vascular dementia |
| | _____ Other _____ |

25. Quality Measure 1: NEW diagnoses given to patient/family:

- Same dx as selected under suspected diagnoses and etiology
 No new dx given → More testing required (e.g. MRI, neuropsych)
 Patient/caregiver already knew the diagnosis
 Patient/caregiver declines information

Other diagnosis given: _____

26. Quality Measure 9: Pharmacological intervention(s):

	Currently using medications			New prescription	Recommendations to be executed by other provider	N/A
	No change	Increase	Decrease/Discontinue			
Cholinesterase inhibitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Namenda®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antianxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Medications: (1) _____ (2) _____

27. Referral(s) made to:

- ADRC and/or DCS Additional testing – Imaging (e.g. MRI)
 WAI Milwaukee Additional testing – Labs
 Alz. Assoc./ADAW Neuropsychology testing
 Research Specialty Evaluation/Treatment (e.g. PT, OT, Speech Therapy, Psychiatry, Sleep)

28. Educational material provided to patient and/or caregiver

- Physical exercise Cognitive exercises
 Disease-specific information Diet/ Nutrition
 Social/community resources Caregiver support (e.g. Memory café, Alz Assoc, ADAW)

29. Quality Measure 2: Caregiver(s) were offered:

- Education regarding Caregiver support
 Disease management
 Health behavior changes
 Referral to programs directed to caregiver(s) support/wellness
 Referral to additional resources to assist the caregiver
 None of the above No caregiver identified
 Caregiver is trained/certified in dementia
 Patient/caregiver are connected to resources
 Decline/Refused

30. Caregiver Burden – Short: _____ Zarit 4-item (0-16)

Data Information Form

Instructions:

This form is to be completed for the patient's initial assessment **only** (not for annual follow-ups or re-evaluations).

It is understood the diagnosis indicated is likely to be a "suspected" or provisional diagnosis. It is also understood that not all of the tests/tools will be used with each assessment and that clinics and clinicians will have their own preferences and protocols to meet the needs of the individuals with whom they work. However, it is critical that each form captures all the information obtained on that patient.

Methods of submission:

1. Online entry, click here: https://is.gd/wai_data_information_form
2. Email MS word version of the form to jkrainer@wisc.edu
3. Fax hard copy version of the form to the attention of Jody Krainer at (608) 265-9122

Each clinic will receive a summary of their clinic's data on an annual basis from Jody Krainer; and the Network's summary will be reviewed at the bi-annual Network Meetings. If you questions or need assistance strategizing on how to achieve 100% submission, please feel free to contact Jody at jkrainer@wisc.edu or at (608) 263-6449.

ABBREVIATIONS KEY:

ACE-R (Addenbrooke's Cognitive Examination-Revised)
AD (Alzheimer's disease)
ADL (activities of daily living)
ADRC (Aging & Disability Resource Center)
Alz. Assoc./ADAW (Alzheimer's Association/Alzheimer's & Dementia Alliance of WI)
bvFTD (Behavioral variant frontotemporal dementia)
DCS (Dementia Care Specialist)
FTD/FTLD (frontotemporal lobar degeneration)
GDS (Geriatric Depression Scale)
IALD (instrumental activities of daily living)
IDD (intellectual developmental disorder)
HIV (human immunodeficiency virus)
LBD (Lewy Body dementia)
M-ACE (Mini- Addenbrooke's Cognitive Examination)
MCI (mild cognitive impairment)
MMSE (Mini Mental State Examination)
MoCA (Montreal Cognitive Assessment)
NPH (Normal Pressure Hydrocephalus)
NPIQ (Neuropsychiatric Inventory Questionnaire)
SLUMS (Saint Louis University Mental Status)
TBI (traumatic brain injury)

N/A: Not applicable

Educational materials provided...EXAMPLES:

Caregiver support/wellness: caregiver stress/stress management, respite
Social and community engagement resources: memory cafés, early stage programs