WAI Clinic Network Data Information Form (8th edition)

1. Clinic Name: _____ **2.Year of Visit:** _____ **3. Length of Visit (mins):** ____

*This form should be completed for **new** patients regarding the patient's **initial** assessment. If the initial assessment is completed across multiple days, complete this form after the patient has consulted with <u>all</u> pertinent members of the care team.*

4. Patient's Age: ☐ ≥90 years ☐ If under 90, write age: ____

5. Gender: ☐ Female ☐ Male ☐ Other

6. Primary Race/Ethnicity:
☐ American Indian or Alaska Native ☐ Asian (e.g. Hmong)
☐ Black / African American ☐ Hispanic/Latino
☐ White ☐ Other: _____

7. Does the patient speak a language other than English at home?
☐ Yes ☐ No

8. Residence: ☐ Lives alone ☐ Assisted living
☐ Lives with other adult ☐ Nursing home ☐ Other: _____

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

10. Chief Complaint/Reason for Visit *(check all that apply)*
☐ Memory/cognitive changes ☐ Behavioral concerns
☐ Diagnosis ☐ 2nd opinion
☐ Treatment recommendations ☐ Family history of dementia
☐ Safety concerns (i.e., driving) ☐ Other: _____

11. Duration of cognitive symptoms (in years): ____

12. 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)

13. Referral Source:
☐ Self/family member ☐ Primary care provider
☐ ADRC/DCS ☐ Other: _____

14. Screening & Recommendations

	***Screened*[1]**		***Issue Identified***		***Did <u>you</u> provide any management or recommendations?*[2]**		
	Yes	No	Yes	No	Yes	No	N/A
Q3: Function, ADLs/IADLS	☐	☐	☐	☐	☐	☐	☐
Caregiver Stress	☐	☐	☐	☐	☐	☐	☐
Q4: Behavioral symptoms	☐	☐	☐	☐	☐	☐	☐
Q4: Depression	☐	☐	☐	☐	☐	☐	☐
Q4: Hallucinations, delusions	☐	☐	☐	☐	☐	☐	☐
Q4: Insomnia or sleep disorder	☐	☐	☐	☐	☐	☐	☐
Q6: Driving safety	☐	☐	☐	☐	☐	☐	☐
Q5: Medication misuse	☐	☐	☐	☐	☐	☐	☐
Q5: Financial mismanagement	☐	☐	☐	☐	☐	☐	☐
Q5: Access to firearms/power tools	☐	☐	☐	☐	☐	☐	☐
Q5: Kitchen safety	☐	☐	☐	☐	☐	☐	☐
Falls	☐	☐	☐	☐	☐	☐	☐
Q8: Pain	☐	☐	☐	☐	☐	☐	☐
Q7: Advanced Directives	☐	☐	☐	☐	☐	☐	☐

[1]*Screening includes use of validated tool, direct assessment of patient, or by querying a knowledgeable informant.*
[2]*If issue is identified, indicate whether management/recommendations were provided. (e.g., of N/A: patient is already being treated elsewhere).*

15. <u>Suspected</u> clinical syndrome diagnoses ***(check all that apply)*:**
☐ Dementia / Major Neurocognitive Disorder
☐ MCI / Mild Neurocognitive Disorder
☐ Normal cognitive testing
↳► ☐ With cognitive complaint ☐ Without cognitive complaint
☐ Undetermined/Still in progress *(still check one of the above)*

16. Suspected etiology/cause associated with diagnosis
Mark "1" next to primary diagnosis and "2" next to secondary diagnosis (mark as many secondary as applicable)
___ Alzheimer's disease ___ Mixed dementia (AD/vascular)
___ Alcohol abuse ___ Parkinson's dementia
___ Depression/anxiety disorder ___ Psychiatric disorder
___ FTD/FTLD ___ Sleep disorder
___ IDD ___ TBI/head injury
___ Lewy body dementia ___ Undetermined
___ Medication-related ___ Vascular dementia
___ Other: _____

17. <u>Quality Measure #1:</u> NEW diagnoses given to patient/family:
☐ Same dx as selected under suspected diagnoses(15) & etiology(1)
☐ No new dx given→☐More testing required (e.g. MRI, neuropsych)
☐Patient/caregiver already knew diagnosis
☐Patient/caregiver declines information
☐No caregiver identified
☐ Other diagnosis given: _____

18. Available and Recommended/Ordered Testing

	Results available for review during visit[1]		**Testing indicated & recommended or ordered**	
	Yes	**No**	**Yes**	**No**
MRI or CT	☐	☐	☐	☐
Other Imaging: _____	☐	☐	☐	☐
Neuropsychology Testing *(beyond what was done in clinic)*	☐	☐	☐	☐
Specialty evaluation (e.g., Psychiatry, Sleep)	☐	☐	☐	☐
Labs	☐	☐	☐	☐

[1]*Check 'Yes' if imaging or lab results were available <u>prior to completion of the initial assessment</u> for use in diagnosis/patient evaluation, whether ordered by your clinic or outside provider in the 6 months before visit.*

19. Educational material provided to patient and/or caregiver:
☐ Caregiver support ☐ Cognitive exercises
☐ MCI/Dementia Information ☐ Diet/Nutrition
☐ Social/community resources ☐ Physical exercise
(e.g. Memory Café, Alz Assoc,)

20. Medical Next Steps *(check all that apply)*
☐ No recommendations at this time, pending additional testing

Initiated or provided recommendations to referring healthcare provider for (check all that apply):
☐ Pharmacologic treatment of MCI/Dementia
☐ Non-pharmacologic treatment of MCI/Dementia
☐ Management of vascular risk factors (DM, HTN, etc.)
☐ Management of mood or anxiety disorders
☐ Management of insomnia and/or sleep disorder
☐ Other:_____

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	☐	☐	☐	☐	☐	☐	☐	☐
Physical aggressiveness	☐	☐	☐	☐	☐	☐	☐	☐
Wandering	☐	☐	☐	☐	☐	☐	☐	☐
Financial mismanagement	☐	☐	☐	☐	☐	☐	☐	☐
Home safety (e.g. issues cooking, trip hazards)	☐	☐	☐	☐	☐	☐	☐	☐
Access to chemicals, firearms, or power tools	☐	☐	☐	☐	☐	☐	☐	☐
20.Q6 Driving safety	☐	☐	☐	☐	☐	☐	☐	☐
21.Q7 Advanced care plan	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

*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
_____ Alcohol abuse
_____ Depression and/or anxiety disorder
_____ FTD/FTLD
_____ IDD
_____ LBD
_____ Medication-related
_____ Mixed dementia (AD/vascular)
_____ Parkinson's dementia
_____ Psychiatric disorder
_____ Sleep disorder
_____ TBI/head injury
_____ Undetermined
_____ 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	☐	☐	☐	☐	☐	☐
Namenda®	☐	☐	☐	☐	☐	☐
Antidepressant	☐	☐	☐	☐	☐	☐
Antianxiety	☐	☐	☐	☐	☐	☐
Antipsychotic	☐	☐	☐	☐	☐	☐
Other (1)	☐	☐	☐	☐	☐	☐
Other (2)	☐	☐	☐	☐	☐	☐

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)