CONSENT FOR DATA COLLECTION OF COGNITIVE ASSESSMENTS

Today you are having a test of your brain's areas of function. The tests that are used allow your doctor to understand more about you.

The results of your assessment when pooled with others will be of great benefit in the future. By signing this consent you are allowing your doctor and the nurse assessor who is performing the test to send the results to a central doctor for analysis. This may also help your doctor to confer with the central cognitive specialist about the information.

The information will not be transmitted with any names attached. It will be transmitted with a patient indentifier number, a doctor indentifier number, a nurse assessor identifier number and some biographical details such as age and years of education and postal code.

The information will be transmitted to Dr. J Ingram Internal Medicine and Geriatric Medicine, J Ingram Geriatric Consulting INC. The information will only be used for educational and research reasons.

We thank you in advance for helping us out and the nurse performing the assessments is likewise very appreciative of your willingness to assist.

I have had an opportunity to fully read and understand this consent and the accompanying request to collect the data from the cognitive assessment.

I give my consent to centralize the data from my assessment.

Printed Name of Patient: ____

Signature of Patient: _______________________Date: _____________________

Printed Name of Caregiver if present: ___________________________________

Signature of Caregiver: _____________________Date: _____________________

Printed Name of Witness: _________________________

Signature of Witness: ______________________Date: _____________________

Cognitive Assessment Tracking Sheet

ASSESSOR, print name: ______________________________

LOCATION:

☐Bancroft ☐Bobcaygeon ☐Bowmanville- 222 King St ☐Bowmanville - Newcastle Medical Centre ☐Brooklin ☐Campbellford ☐Courtice ☐Fenelon Falls ☐Haliburton ☐Kinmount

☐Kirkfield ☐Lakefield ☐Lindsay-Med Centre Site1 ☐Lindsay-Med Centre Site2 ☐Oshawa-Oshawa Clinic ☐North Oshawa Clinic ☐Oshawa-Taunton Med Centre ☐Oshawa-Whitby Mall

☐PTBO Clinic ☐PTBO Med Centre ☐PTBO-Brookdale Clinic ☐PTBO-Burnham Clinic ☐PTBO-Scott Clinic ☐Port Perry ☐Whitby Clinic ☐Byron Street Clinic ☐Dundas Med Centre

☐Other: ______________________________

									CHANGE IN ORDER!			TRAILS		optional	optional		
Assessment Date MM/DD/YYYY	Patient Initials	DOB MM/DD/YYY	Age	Education <=12 or >12	Referring Physician	MMSE World - 7s	Clock (/4)	MIS (/8)	F-S-A			A (sec/ %ile)	B (sec/ %ile)	BNT (/15)	Loops/ Ramparts N/ABN	Currently taking Reminyl, Exelon, Aricept or Memantine	Previously assessed by NCA? No-Yes, date (MM/DD/YYY)
				☐ <=12 ☐ >12					F	S	A	/	/				NO YES __/__/__
				☐ <=12 ☐ >12					F	A	S	/	/				NO YES __/__/__
				☐ <=12 ☐ >12					F	A	S	/	/				NO YES __/__/__
				☐ <=12 ☐ >12					F	A	S	/	/				NO YES __/__/__
				☐ <=12 ☐ >12					F	A	S	/	/				NO YES __/__/__
				☐ <=12 ☐ >12					F	A	S	/	/				NO YES __/__/__
				☐ <=12 ☐ >12					F	A	S	/	/				NO YES __/__/__
				☐ <=12 ☐ >12					F	A	S	/	/				NO YES __/__/__

NURSE ASSESSOR SIGNATURE ______________________________

DATE OF SUBMISSION ______________ (MM/DD/YYYY)

FAX CONSENT, RAW DATA, INDIVIDUAL SUMMARY SHEET AND COGNITIVE ASSESSMENT TRACKING SHEET

FAX TO: (705) 749-2778

COGNITIVE SCREENING – PAGE 1

NAME: ____________________________________

DATE (MM/DD/YYYY): ______________________

DOB (MM/DD/YYYY): _______________________

POSTAL CODE: ________________

FAMILY PHYSICIAN:________________________

MEDICAL RISK FACTORS (Check all that apply):

CAD ☐ CVA ☐ HYPERLIPIDEMIA ☐

HEAD INJURY ☐ If YES, specify ______________________________

FAMILY HX DEMENTIA ☐ ONSET: RAPID ☐ GRADUAL ☐

HYPERTENSION ☐ DIABETES ☐ THYROID ☐

MEDICATIONS (LIST): ___________________ _____________________

___________________ _____________________

___________________ _____________________

DRIVING Yes ☐ No ☐

SMOKING Yes ☐ No ☐

If yes, how long: __________ How many per day: __________

ALCOHOL Yes ☐ No ☐

If yes, indicate amount per week: _________

CONCERNS:

NEURO-COGNITIVE SCREENING – Page 2

DATE: _____/____/________
MM / DD / YYYY

Patient's Name: ____________________________________

D.O.B.: _____/____/________
MM / DD / YYYY

EDUCATION (indicate highest level completed):

Elementary, grade ____ High School, grade ____ College ____
University ____ Trade School ____ Other, specify ________

FAMILY PHYSICIAN: _______________________________

MMSE: /30

CLOCK DRAWING: /4

TRAILMAKING (Executive function): Trails A: /sec. / % ile*
(use Nomogram2004, Tambaugh) Trails B: /sec. / % ile

BOSTON NAMING TEST :(optional) /15

MEMORY IMPAIRMENT SCREEN: /8

LUREA SQUENCES: Normal:
Abnormal:

CONTROLLED ORAL WORD ASSOCIATION: F/ S/ A/

Patient on Cholinesterase inhibitors? (Reminyl, Aricept, Exelon) NO YES

Has patient been tested before with NCA's NO YES
If Yes, When _____/____/________
MM / DD / YYYY

COMMENTS:

NURSE ASSESSOR:
____

NEUROCOGNITIVE ASSESSMENT (NCA) FEEDBACK QUESTIONNAIRE

TELL US ABOUT THE ASSESSMENT YOU DO:

1. How long have NCA's been performed in your office? Since 2005 2006 2007 2008

2. Most NCA's are performed:

   a) As part of a patient encounter/visit if a patient presents needing this Y / N
   b) Scheduled on a separate later day with nurse/NCA assessor? Y / N

3. Do you have a space that is quiet where NCA's can be performed? Y / N

4. The K032 code allows you to bill OHIP for each assessment:

   A. Do you bill OHIP for NCA assessment? All Some None
   B. Do you intend to bill OHIP for NCA assessments in the future? All Some None
   C. If visiting assessors were not available:

      a) Would you continue NCA assessments? Y / N
      b) Would the frequency of NCA assessments: Decrease Stay same Increase

   Comments:____

TELL US ABOUT THE VALUE OF THE INFORMATION ASSESSMENTS:

1. On a scale of 1-5 how helpful are the NCA results?

Not helpful				very helpful
1	2	3	4	5

2. Does the testing provide families useful information or insight? Y / N

3. How helpful are NCA assessments in helping to guide your counseling/information to the family? Very Moderate Not useful

4. Have the assessments provided you with diagnostic information not available through Dialogue/MMSE? Y / N

5. Have the assessments assisted in decisions about:
   - Driving Y / N
   - Ability to manage finances Y / N
   - Ability to cook Y / N
   - Ability to manage medications Y / N
   - Ability to live alone Y / N
   - The need for long term care Y / N

TELL US

6. As a result of doing NCA's are you noticing a change in:

	Increase	Decrease	About the Same
• Consultant referrals	____	____	____
• Memory clinic referrals (WMHC/TOR/Kingston)	____	____	____
• Neurology referrals	____	____	____
• Psychiatry referrals	____	____	____
• Long Term Care Referrals	____	____	____
• Access Centre in home help referrals	____	____	____
• Day Centre referrals	____	____	____
• Alzheimer Society Referrals	____	____	____

Comments:____
____
____

TELL US ABOUT THE IMPACT OF THE NCA PROJECT:

1. Has the project had any impact on the management of dementia in your region as the result of NCA availability ?

• Dementia evaluations	Improved	Same	More complicated
• Dementia awareness	Improved	Same	More complicated
• Identification of potential dementias	Improved	Same	More complicated
• Collaboration with family	Improved	Same	More complicated
• Collaboration with staff	Improved	Same	More complicated

2. Do you want to continue doing/having NCA's performed? Y / N

3. Do you still need the NCA's to be provided by outside nurses? Y / N

4. Is there a nurse who could perform NCA's for you in the future? Y / N

Comments:
____
____

____
Signature (optional)

TELL US

NEUROCOGNITIVE SCREENING PATIENT DEMOGRAPHICS

ASSESSMENT DATE ☐☐-☐☐-☐☐☐☐
MM DD YYYY

PATIENTS INITIALS ☐☐ AGE ☐☐ DOB ☐☐-☐☐-☐☐☐☐
MM DD YYYY

POSTAL CODE ☐☐☐ ☐☐☐

EDUCATION ☐ <=12 ☐ >12 Specify Highest Grade Completed:___________

ASSESSMENT ☐ Initial ☐2nd ☐3rd

Date of Previous Assessment: ☐☐-☐☐-☐☐☐☐
MM DD YYYY

REFERRING PHYSICIAN ____________________________(print clearly)

ASSESSOR____(print clearly)

CITY-CLINIC SITE

☐Bancroft	☐Bobcaygeon	☐Brooklin
☐Bowmanville-222 King	☐Bowmanville-Newcastle	
☐Campbellford	☐Courtice	☐Fenelon Falls
☐Haliburton	☐Kinmount	☐Kirkfield
☐Lakefield	☐Lindsay Medical Centre Site1	☐Lindsay Medical Centre Site2
☐Oshawa Clinic	☐PTBO Clinic	☐Port Perry
☐North Oshawa Clinic	☐PTBO Med Centre	☐Whitby Clinic
☐Oshawa-Taunton	☐PTBO Brookdale	☐Whitby-Byron St
☐Oshawa-Whitby Mall	☐PTBO Burnham	☐Whitby-Dundas Med Centre
	☐PTBO Scott Clinic	

☐Other: ____

REASON FOR REFERRAL (check all that apply):

☐Office Staff/MD Witness Memory Problems	☐Family Report Memory Problems
☐Patient Reports Memory Problems	☐Behavioural Concerns
☐Driving Concerns	☐Family History of Dementia Positive
☐Episodes of Delirium	☐Recent Major Health Events (Stroke, CABG)

☐Other, specify:___________________________

NEUROCOGNITIVE SCREENING PATIENT DEMOGRAPHICS

PATIENTS INITIALS ☐☐ AGE ☐☐ DOB ☐☐-☐☐-☐☐☐☐
MM DD YYYY

ASSESSMENT DATE ☐☐-☐☐-☐☐☐☐
MM DD YYYY

MEDICAL DIAGNOSIS (check all that apply):

☐Elevated BP
☐Diabetes
☐Renal Insufficiency
☐Rheumatoid Arthritis
☐Pulmonary Hypertension
☐Parkinson's
☐Hypothyroid
☐Atrial Fibrillation
☐MI / CAD
☐Stroke / CVA completed
☐TIA
☐CABG-Valve Replacement
☐Head Injury
☐Elevated Cholesterol
☐Osteoporosis
☐Other, specify:______________________

FOR THE PURPOSES OF RESEARCH, PLEASE LET US KNOW:

Is there a history of DEPRESSION? ☐Yes ☐No
Medicated for Depression? ☐Yes ☐No
ECT for Depression? ☐Yes ☐No
Hospitalized for Depression? ☐Yes ☐No
Is the patient currently DRIVING? ☐Yes ☐No
Does the patient drink ALCOHOL? ☐Yes ☐No
Frequency of Alcohol consumption: ☐Never ☐Rarely (1 drink/week) ☐1-3 Days per Week ☐Daily
Amount of Alcohol Consumed is: ☐ 1-2 drinks per day ☐ 3-4 drinks per day ☐ >4 drinks per day
Has excess alcohol consumption been identified as occurring in the last 3 months?
☐Yes ☐No

MEDICATION? ☐Narcotics, specify_____________________________________
☐Antidepressants, specify________________________________
☐Benzodiazepines, specify_______________________________
☐Anxiety/Sleep Meds, specify_____________________________
☐Cardiac Meds, specify__________________________________
☐Other, specify____