

Framingham Heart Study

Manual of Procedures

MOP-version 1.0

August 22, 2018

Research Examination Center

Generation 3, Omni 2, NOS Cohorts Examination 3

Section #8b Neurocognitive Questionnaire – Referral Forms

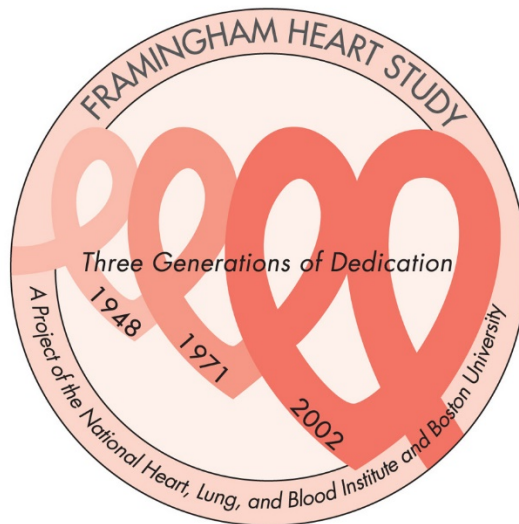


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1.0 Cognitive Center Referral Form

Cognitive Center Referral Form											
<i>Version 07/16/2008</i>											
Participant Name											
FHS ID	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">-</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>		-								
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Date of Referral (mm/dd/yyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			/			/				
		/			/						
Initials and ID # of Person Making Referral	Initials: _____ ID number: _____										

Referral Source <i>(Circle one)</i>	1 Clinic	2 Hospital Surveillance	3 Neuropsych Testing	4 Health Update	5 Medical records	6 Other <i>(describe below)</i>
Reason for referral: _____ _____ _____						
<i>(continue on back)</i>						
Is informant present with participant at time of referral? <i>(Circle one)</i>	1=Yes	2=No				
If yes, list informant information (name, phone number, address, relationship to participant):						
Name: _____ Relationship to participant: _____						
Address: _____ _____						
Phone #: _____ _____						

Contact Information <i>(To be filled out by Cognitive Clinic Recruiter only) (NOT KEYED)</i>		
Does the participant live in Massachusetts?	0=No	1=Yes

If no, where does the participant live (city, state)?	_____, _____		
Can the participant be contacted?	0=No	1=Yes	8=N/A
If the participant cannot be contacted, please explain reason:			

2.0 Stroke Tracking Referral Form

Stroke Tracking Referral Form The Framingham Study

* Please complete the upper portion of this form if you identify a new neurological event.

ID#: _____ Name: _____
Date Opened: ____/____/____
Date of Event: ____/____/____ Date Type: ____ (0=Exact, 1=Approximate)
Source of Referral: _____
1 = Hospital Admission 5 = Medical Records
2 = Biennial Exam 6 = Review
3 = Offspring Exam 7 = Other (Please specify)
4 = Family
Initials: _____
Reason for Referral: _____
Reason for Hospitalization: _____ (1=Neurology, 2=Other, 8=NA)
Comments: _____

DISPOSITION (FOR TRACKING PERSONNEL TO COMPLETE)

1. Dictation: _____ (0=Awaiting, 1=In)
2. To be Scheduled in Stroke Center: _____ (0=No, 1=Yes, 2=Pending)
3. Date Seen in Stroke Center: ____/____/____
4. Reason Not Seen in Center: _____ (1=NA, 2=Refused, 3=Deceased, 4=Out of State)
5. Part of PSIP Follow-Up Protocol: _____ (0=No, 1=Yes, 9=Unknown)
6. Previously Seen: _____ (0=No, 1=Stroke, 2=Dementia, 3=Other)
7. Medical Records needed: _____ (0=No, 1=Yes)
8. Date: ____/____/____
9. CT/MRI/MRA to be obtained: _____ (0=No, 1=Yes)
10. Date: ____/____/____
11. Review Status: _____ (1=Awaiting Review, 2=Reviewed, 3=Need Info)
12. Date Reviewed: ____/____/____
13. Status of Case: _____ (1=Open, 2=Closed)
14. Date: ____/____/____
15. Diagnosis: _____
(1=Stroke, 2=TIA, 3=? TIA, 4=Parkinson's, 5=No CVA, 6=Other Neuro, 7=Migraine, 10=?Stroke, 20=Recurrent TIA, 9=Unknown)