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
Tracking of Revisions to this FHS Protocol MOP

<table>
<thead>
<tr>
<th>Revised Section</th>
<th>Date (s) of Revisions; source</th>
<th>Approved by, Date</th>
<th>Revisions</th>
<th>Previous Pages #s section changed</th>
<th>Distribution Date</th>
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</tr>
</tbody>
</table>
Table of Contents

1.0  Cognitive Center Referral Form ................................................................. 4
2.0  Stroke Tracking Referral Form ................................................................. 6
## 1.0 Cognitive Center Referral Form

### Cognitive Center Referral Form

<table>
<thead>
<tr>
<th>Participant Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FHS ID</td>
<td></td>
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<tr>
<td>Date of Referral (mm/dd/yyyy)</td>
<td></td>
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<tr>
<td>Initials and ID # of Person Making Referral</td>
<td>Initials: ___________   ID number: _____________________</td>
</tr>
</tbody>
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**Referral Source**  
(Circle one)

<table>
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<tr>
<th>Referral Source</th>
<th>1 Clinic</th>
<th>2 Hospital Surveillance</th>
<th>3 Neuropsych Testing</th>
<th>4 Health Update</th>
<th>5 Medical records</th>
<th>6 Other (describe below)</th>
</tr>
</thead>
</table>

Reason for referral: ____________________________________________________________

(continue on back)

Is informant present with participant at time of referral? (Circle one)  
1=Yes  2=No  8=N/A

If yes, list informant information (name, phone number, address, relationship to participant):

Name: _______________________________  Relationship to participant: ________________________________

Address: ________________________________

Phone #: ________________________________

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**Contact Information**  
(To be filled out by Cognitive Clinic Recruiter only) (NOT KEYED)

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)