British Women's Heart and Health Study

Name:

Date of birth: Address:

NHS Number:

Practice ID: Postcode:

Please attach a photocopy of the hospital letter or discharge summary
Or fill in this whole form, for the event on this date

Dementia Validation Form

1.0 Date of Diagnosis: [ ]

		Cognitive test	Score
2.0	How severe is dementia?		
2.1	At time of diagnosis (if available)	________	________
2.2	Latest measurement (if available)	________	________

		Yes	No
3.0	Was the diagnosis made during:		
3.1	A hospital admission?	☐1	☐2
3.2	A "memory clinic" appointment	☐1	☐2
3.3	A review by the community mental health team	☐1	☐2
3.4	A review by the GP	☐1	☐2

		Yes	No
4.0	Has the patient being classified into any of the following types of dementia?		
4.1	Alzheimer disease	☐1	☐2
4.2	Vascular dementia	☐1	☐2
4.3	Mixed Alzheimer/vascular dementia	☐1	☐2
4.4	Lewy body dementia/Parkinson's disease dementia	☐1	☐2
4.5	Frontal lobe dementia/Pick's disease/Progressive aphasia	☐1	☐2
4.6	Unable to classify	☐1	☐2
4.7	Other ______________________		

		Yes	No
5.0	Has the patient been prescribed or is currently taking any of the following medications?		
5.1	Donepezil hydrochloride	☐1	☐2
5.2	Galantamine hydrobromide	☐1	☐2
5.3	Memantine hydrochloride	☐1	☐2
5.4	Rivastigmine	☐1	☐2

		Yes	No	If abnormal please report: Levels (units) and date (DD/MM/YY)
6.0	If the patient has dementia, did she ever complete a "confusion screening" for any of the following?			
6.1	Vitamin B12 deficiency	☐1	☐2	______________

		Yes	No	
6.2	Folate deficiency	☐1	☐2	________
6.3	Thyroid deficiency	☐1	☐2	________
6.4	Liver functional tests	☐1	☐2	________
6.5	Brain scan (MRI and/or CT)	☐1	☐2	
	Please, indicate if any of the following			**Region involved**
6.6	Brain atrophy	☐1	☐2	________
6.7	Stroke	☐1	☐2	________
6.8	Small vessels disease	☐1	☐2	________

		Yes	No
7.0	Has the patient (or her family) referred any of the following symptoms around the time of diagnosis?	**Yes**	**No**
7.1	Acute confusion (Delirium)	☐1	☐2
7.2	Anxiety	☐1	☐2
7.3	Depression	☐1	☐2
7.4	Personality changes	☐1	☐2

		Yes	No	Score
8.0	Did the patient have any of the following tests performed?	**Yes**	**No**	**Score**
8.1	Eight-item Informant Interview to Differentiate Aging and Dementia (AD8)	☐1	☐2	____
8.2	General Practitioner Assessment of Cognition (GPCOG)	☐1	☐2	____
8.3	6-Item cognitive test (6CIT)	☐1	☐2	____
8.4	Mini-Cog	☐1	☐2	____
8.5	MMSE	☐1	☐2	____
8.6	MoCA	☐1	☐2	____
8.7	AMTS	☐1	☐2	____
8.8	Other: ________________			**Score**: ________

<u>If the answer to any of the questions above is YES, please provide a letter of discharge and/or copy of all cognitive test performed if available</u>

9.0 Comments:

Reviewers Name: …………………………………………………….Date: ...…../…..…/………..

For Office Use Only:
BWHHS Record Review Round 6
Version 1

Study ID: