University of Pittsburgh

Alzheimer Disease Research Center

UPMC Montefiore, 4 West
200 Lothrop Street
Pittsburgh, PA 15213-2582
412-692-2700
Fax: 412-692-2710

Dear Friends:

Thank you for your inquiry about the University of Pittsburgh Alzheimer Disease Research Center (ADRC). Attached is an application which asks for background and health status information about the applicant. Please complete and return the form to the Alzheimer Disease Research Center, 4 West, UPMC Montefiore, 200 Lothrop Street, Pittsburgh, PA 15213.

An appointment at the ADRC involves interviews with several members of our research team and will last about 4 hours. The visit will include a series of interviews, examinations and tests to evaluate memory and other cognitive functions. Blood will be drawn for research purposes. If you have already had a brain scan (PET scan, MRI or CT) please bring it to the first appointment. If not, we will arrange a scan as part of your evaluation. All ADRC participants are required to bring a "study partner" to the visit. This is someone who knows the participant well, such as a spouse, child or friend who sees the participant very frequently. The study partner will also be interviewed to provide information about the participant's health status, memory and behavior.

We hope that those who undergo an evaluation will join us as committed partners in the fight against Alzheimer's disease and related disorders by participating in additional research studies. These may include brain imaging studies, genetic studies, tests of new medications for Alzheimer's disease and studies of patients with AD.

If you have further questions regarding participating in research, or the application materials, please contact Donna Simplon at 412-692-2700. We will be in touch with you by telephone once we have received the completed application.

Kind regards,

Professor of Neurology, Psychiatry & Clinical and Translational Sciences
Director, ADRC
Levidow – Pittsburgh Foundation Endowed Chair in Alzheimer's Disease
And Dementia Disorders

University of Pittsburgh
Alzheimer's Disease Research Center

Participant Application

Date ________________

Applicant Information:

Name: ____
Last First MI

Address: ____
Street City State Zip

Telephone: (____)______________ (____)______________ (____)______________
Primary Secondary Other

Does applicant live in a different location for part of the year? ☐ Yes ☐ No

If "Yes," When: __________________ Where: ______________________________

Email address (please provide if you are interested in receiving informational emails from the Alzheimer's Disease Research Center):______________________________

Age: ______ Sex at Birth: ☐Male ☐Female Gender:________ Preferred Pronoun:_________

Highest grade or degree completed: ______________________________

Study Partner - a family member or friend who will accompany applicant to visit (required):

Name: ____
Last First MI

Address: ____
Street City State Zip

Telephone: (____)______________ (____)______________ (____)______________
Primary Secondary Other

Email address (please provide if you are interested in receiving informational emails from the Alzheimer's Disease Research Center):______________________________

Relationship to applicant: ______________________________

How much contact/time spent with the applicant: ______________________________

Person Completing Application (check one):

☐ Applicant ☐ Study Partner ☐ Other (if *Other* please complete contact information below):

Name: ____
Last First MI

Address: ____
Street City State Zip

Telephone: (____)______________ (____)______________ (____)______________
Primary Secondary Other

Relationship to applicant: ______________________________

How much contact/time spent with the applicant: ______________________________

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Participant Application

Why does the applicant want to come to the Alzheimer's Disease Research Center (ADRC)?

____

____

How did you learn about the ADRC? ____

Does the applicant believe they are experiencing memory or thinking problems? ☐ Yes ☐ No
If "Yes," briefly describe symptoms:____

____

Does the study partner or anyone else believe the applicant is experiencing memory or thinking problems? ☐ Yes ☐ No
If "Yes," briefly describe symptoms: ____

____

Has the applicant had an evaluation for memory or thinking? ☐ Yes ☐ No ☐ Don't know

If "Yes," When: ____________________ Where: ____________________________

Was a diagnosis given? ☐ Yes ☐ No ☐ Don't know

If "Yes," what was the diagnosis? ____

A major focus of the ADRC is to match applicants with opportunities to volunteer for additional research studies related to Alzheimer's disease based on their interests and the eligibility requirements of the research. Which of the following types of research is there an interest in learning more about? (check all that apply)

☐ Brain Imaging (MRI, PET, etc.)
☐ Interviews/Questionnaires
☐ Brain Donation/Brain Autopsy Program
☐ Treatment Trials (e.g., medication or exercise)
☐ Family/Caregiver Studies
☐ Genetic Studies

Applicant Demographic Information:

Present living arrangement: (check one)
☐ Alone ☐ Spouse/Partner ☐ Other Relative ☐ Retirement Community
☐ Assisted Living ☐ Nursing Facility ☐ Other (specify) ___________________________

Ethnicity - Hispanic/Latino? ☐ Yes ☐ No

Race: (check all that apply)
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Other

Native Language: (check one) ☐ English ☐ Other (specify): ______________________

If native language is other, age when applicant learned English:_________________________

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Participant Application

Memory, Thinking, Behavior, and Functional Information:

Please rate each question about the applicant by checking (✓) the appropriate box:

	Always	Usually	Sometimes	Rarely	Never	Don't know
Does applicant…						
…recognize the faces of family and friends?	☐	☐	☐	☐	☐	☐
…remember the names of family and friends?	☐	☐	☐	☐	☐	☐
…remember her/his address or telephone number?	☐	☐	☐	☐	☐	☐
…remember what day or month it is?	☐	☐	☐	☐	☐	☐
…remember where things are usually kept?	☐	☐	☐	☐	☐	☐
…make sense in conversation?	☐	☐	☐	☐	☐	☐
Is applicant able to write her/his name?	☐	☐	☐	☐	☐	☐

Please rate each question about the applicant by checking (✓) the appropriate box:

	Never	Rarely	Sometimes	Usually	Always	Don't know
Does applicant seem confused?	☐	☐	☐	☐	☐	☐
Has applicant heard sounds or voices or seen things that no one else can hear or see?	☐	☐	☐	☐	☐	☐
Is applicant agitated or aggressive?	☐	☐	☐	☐	☐	☐
Is applicant currently depressed?	☐	☐	☐	☐	☐	☐

Please rate the applicant's ability to perform the following activities, by checking (✓) the appropriate box:

	Able to do independently	Needs prompts and/or reminders	Needs assistance to do	Unable to do	Does not apply	Don't know
Using the telephone	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Cooking/food preparation	☐	☐	☐	☐	☐	☐
Household chores/minor repairs	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐
Managing medications	☐	☐	☐	☐	☐	☐
Managing money/handling finances	☐	☐	☐	☐	☐	☐
Bathing/personal grooming	☐	☐	☐	☐	☐	☐
Dressing (including selecting clothing)	☐	☐	☐	☐	☐	☐
Going to the bathroom	☐	☐	☐	☐	☐	☐

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Does the applicant have a current driver license? ☐Yes ☐No
Is the applicant driving? ☐Yes ☐No
If yes, check all that apply:

☐ Driving without problems
☐ Becomes lost
☐ Medical limitations (i.e.-vision, mobility)
☐ Needs assistance when driving (i.e.-help with directions)
☐ Only drives locally
☐ Minor dings and scrapes on car
☐ At fault accidents

<u>Medical Conditions:</u>

Please indicate whether the applicant has any of the following conditions.
Mark 'Yes' or 'No' and then add any additional information or details you'd like us to know.

Medical Conditions	No	Yes	Additional Information
Heart Attack (Myocardial Infarction/"Coronary")	☐	☐	
Open heart surgery What type? (Stent, Bypass, Valve replacement, etc.) ______________________________________	☐	☐	
Congestive heart failure, heart failure	☐	☐	
High blood pressure / Hypertension	☐	☐	
Elevated cholesterol and/or triglycerides	☐	☐	
Diabetes / "sugar" / High blood sugar	☐	☐	
Stroke / brain hemorrhage / or brain embolism	☐	☐	
TIA (transient ischemic attack/"mini-stroke")	☐	☐	
Brain surgery What type? (Aneurysm, Repair, Tumor removal, etc.) ______________________________________	☐	☐	
Head injury where the applicant lost consciousness (i.e., was "knocked out") When? ______________________________ How long was the applicant unconscious? ___________	☐	☐	
Parkinson's disease	☐	☐	
Cancer in the last 5 years What type? ____________________________	☐	☐	
Thyroid disease	☐	☐	
Rheumatoid arthritis or Lupus	☐	☐	
Kidney disease or kidney dialysis	☐	☐	
Seizure disorder / Epilepsy	☐	☐	
HIV (Human immunodeficiency virus) or AIDS	☐	☐	
Leukemia or other blood diseases What type? ______________________________________	☐	☐	

Participant Application

Additional Medical Questions:

Please answer some additional medical questions.
Mark 'Yes' or 'No' and then add any additional information or details you'd like us to know.

Additional Medical Questions	No	Yes	Additional Info
Does the applicant currently drink alcohol?	☐	☐	
Has alcohol consumption ever been a problem?	☐	☐	
Does the applicant have a history of drug abuse? When was this? ______________________________	☐	☐	
Has the applicant ever been given a diagnosis of schizophrenia?	☐	☐	
Has the applicant been treated for depression in the past?	☐	☐	
Has the applicant ever received electroconvulsive therapy, ECT (shock treatments)? How many treatments? _____ What year(s)? _____________	☐	☐	
Has the applicant ever been given a diagnosis of manic/depression or bipolar disorder?	☐	☐	
Does the applicant have hearing loss that would interfere with understanding spoken instructions?	☐	☐	
Does the applicant have visual impairments that would interfere with performing simple paper and pencil tests?	☐	☐	

Please tell us about any other medical conditions or procedures that have not been covered:

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Medications:

Please **list any prescription medications** the applicant is taking.
Please **include how often** the medication is taken.

☐ No prescription medications ☐ Don't know

Example: Lipitor, once a day

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Mail your completed application to:

Alzheimer's Disease Research Center
UPMC Montefiore, 4th floor, suite 421
200 Lothrop Street
Pittsburgh, PA 15260

Or fax to:

(412) 692-2710

Or email to:

ADRCAdmin@upmc.edu