



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 the ADRC at 412-692-2700. We will be in touch with you by telephone once we have reviewed the completed application.

Kind regards,

A handwritten signature in cursive script, appearing to read "Owen Lopez".

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: _____



Participant Application

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

Two horizontal lines for text input.

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:

Horizontal line for text input.

Does the study partner or anyone else believe the applicant is experiencing memory or thinking problems? [] Yes [] No

If "Yes," briefly describe symptoms:

Horizontal line for text input.

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

If "Yes," When: Where:

Horizontal line for text input.

Was a diagnosis given? [] Yes [] No [] Don't know

If "Yes," what was the diagnosis?

Horizontal line for text input.

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:



**University of Pittsburgh
Alzheimer's Disease Research Center**

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...remember the names of family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...remember her/his address or telephone number?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...remember what day or month it is?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...remember where things are usually kept?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...make sense in conversation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is applicant able to write her/his name?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Never	Rarely	Sometimes	Usually	Always	Don't know
Does applicant seem confused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has applicant heard sounds or voices or seen things that no one else can hear or see?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is applicant agitated or aggressive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is applicant currently depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking/food preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household chores/minor repairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing money/handling finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing/personal grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing (including selecting clothing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Participant Application

Does the applicant have a current driver license? Yes No

Is the applicant driving? Yes No

If yes, check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Driving without problems | <input type="checkbox"/> Needs assistance when driving (i.e.-help with directions) |
| <input type="checkbox"/> Becomes lost | <input type="checkbox"/> Only drives locally |
| <input type="checkbox"/> Medical limitations (i.e.-vision, mobility) | <input type="checkbox"/> Minor dings and scrapes on car <input type="checkbox"/> At fault accidents |

Medical Conditions:

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")	<input type="checkbox"/>	<input type="checkbox"/>	
Open heart surgery What type? (Stent, Bypass, Valve replacement, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Congestive heart failure, heart failure	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure / Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Elevated cholesterol and/or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes / "sugar" / High blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke / brain hemorrhage / or brain embolism	<input type="checkbox"/>	<input type="checkbox"/>	
TIA (transient ischemic attack/"mini-stroke")	<input type="checkbox"/>	<input type="checkbox"/>	
Brain surgery What type? (Aneurysm, Repair, Tumor removal, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Head injury where the applicant lost consciousness (i.e., was "knocked out") When? _____ How long was the applicant unconscious? _____	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer in the last 5 years What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid arthritis or Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease or kidney dialysis	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure disorder / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
HIV (Human immunodeficiency virus) or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Leukemia or other blood diseases What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	



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?	<input type="checkbox"/>	<input type="checkbox"/>	
Has alcohol consumption ever been a problem?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the applicant have a history of drug abuse? When was this? _____	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant ever been given a diagnosis of schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant been treated for depression in the past?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant ever received electroconvulsive therapy, ECT (shock treatments)? How many treatments? _____ What year(s)? _____	<input type="checkbox"/>	<input type="checkbox"/>	
Has the applicant ever been given a diagnosis of manic/depression or bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the applicant have hearing loss that would interfere with understanding spoken instructions?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the applicant have visual impairments that would interfere with performing simple paper and pencil tests?	<input type="checkbox"/>	<input type="checkbox"/>	

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

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