Caddy CRF

Thank you! The details you entered match those in our database for this participant.

Please answer the questions below for Participant [record_id]

IMPORTANT:
To protect patient confidentiality please do not include any identifying information on the form beyond what is specifically requested.

For further guidance please contact Clare Aldus at c.aldus@uea.ac.uk or telephone ▓▓▓▓▓▓▓

Participant [record_id]: [gender], born [monthofbirth] [yearofbirth]

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Section 2. Dementia Diagnosis

If the patient has ever been diagnosed with dementia then mark 'Yes' and complete the rest of this section. If not then mark 'No' and move to the next section.

1   Has the patient ever been diagnosed with ANY form of dementia?   ○ Yes
                                                                            ○ No

Please record the earliest date on which a diagnosis of dementia is recorded in the patient's records and the specific read code used to record this diagnosis.

2   Date of Dementia Diagnosis   --------------------------------------

3   Read code used to record diagnosis (if available):   --------------------------------------

Please also enter the date at which the patient was first entered on the practice dementia register if applicable.

4   Date of entry on practice dementia register: --------------------------------------

Date of entry onto Practise register should be later than date of diagnosis ([dementia_diag_date])!

We are interested in how the process of dementia diagnosis was initiated, whether it was a referral from hospital, self or family concerns, your own concerns or other. Please indicate the pathway to diagnosis for the patient by selecting the most appropriate category. If the specific pathway for the patient is not presented as a choice then please briefly describe the pathway for the patient (e.g. the practice nurse raised concerns).

5   Pathway to Diagnosis:

○ referral from GP following self-complaint
○ referral following family complaint
○ referral following GP concern or GP initiated cognitive test
○ referred following acute admission or outpatient appointment
○ other
○ No Information

6   Please tell us about any other pathway to diagnosis:

Participant [record_id]: [gender], born [monthofbirth] [yearofbirth]

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Section 3. Memory or other cognitive concerns and tests

We are interested in when a cognitive concern was first raised for a patient, even if this did not lead to a diagnosis or referral. Please complete this section whether or not a dementia diagnosis is recorded in section 2 above.

If a memory or other cognitive concern is recorded for this patient (prior to dementia diagnosis or if no dementia diagnosis) then mark 'Yes' and complete the rest of this section. If not then mark 'No' and move to the next section.

7   Memory or other cognitive concern recorded   ○ Yes
                                                            ○ No

Please record the earliest date on which a memory concern was raised and indicate the source of the concern.

8   Date of first memory or other cognitive concern: _____

Date of first concern should be prior to date of diagnosis ([dementia_diag_date])!

9   Concerns first raised by:

○ Patient
○ Family member or supporter
○ General Practitioner
○ Other Professional
○ Other

10   Other- Please specify   _____

11   Read code applied, (if available)   _____

12   Name of initial cognitive test administered in   _____
     primary care (if any)

13   Date cognitive test carried out   _____

Date cognitive test carried out should be later than date first concern recorded ([memory_concern_date])!

Participant [record_id]: [gender], born [monthofbirth] [yearofbirth]

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Section 4. Referral to Specialist Dementia Services

Please indicate whether the patient was ever referred to a specialist dementia service for diagnosis and, if so, please tell us which service this was (e.g. 'memory clinic') the date of the referral and the date on which the result was recorded.

14 Referral to specialist dementia services (e.g. Memory Clinic)?
- ○ Yes
- ○ No

15 Type of specialist service
- ○ Psychiatric Memory Clinic
- ○ Community Mental Health Trust
- ○ Neurology Department
- ○ Geriatric Memory Clinic
- ○ Primary care liaison practitioner
- ○ Other

Name of other specialist service: ------------------------------------

16 Date of first referral: ------------------------------------

Date referred to memory service should be after date of cognitive test([memory_test_date])!

Please briefly name or describe the diagnosis or findings provided by the specialist service or, if applicable, non-attendance at the specialist service. If available, please also provide the Read Code used to record this outcome.

17 Did the patient attend the memory service appointment?
- ○ Yes
- ○ No
- ○ Not Known

18 Date outcome/response to referral recorded: ------------------------------------

Date outcome recorded should be after date of referral ([referral_date])!

19 Outcome (diagnosis/findings) of referral to specialist service

20 ReadCode (if available) ------------------------------------

Participant [record_id]: [gender], born [monthofbirth] [yearofbirth]

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Section 5. Leaving the Practice

Please mark 'Yes' or 'No' to indicate whether the patient is still registered at your practice.

21 Patient still registered at the practice?   ○ Yes
                                                        ○ No

If the patient is not still registered then please indicate whether the patient has died or has left the practice, and the date of death or leaving the practice if known.

22 Died or left practice?   ○ died
                                                        ○ left practice

23 Date of death or leaving: ----------------------------------

Please enter your own job title.

24 Job title of person completing the form: ----------------------------------

If there is any other information that you feel is relevant, for example that the patient's records no longer exist then please enter this information in the space provided.

25 Any other relevant information: