INITIAL VISIT PACKET NACC UNIFORM DATA SET (UDS) **DOWN SYNDROME MODULE**

Form D1D: Clinician Exam and Diagnosis

ADC name: _____ Subject ID: _ _ _ _ _ _ _ _ _ _ Form date: _ _ / _ _ / _ _ _ _

Visit #: _ _ _ Examiner's initials: _ _ _

*INSTRUCTIONS: This form is to be completed by the clinician. For additional clarification and examples, see **Down Syndrome Coding Guidebook** for **Initial Visit Packet, Form D1D**. Check only one box per question.*

1. Head circumference	___ ___ ___ cm *(888 = Not assessed)*
2. Pathological reflexes — grasp	☐ 1 Absent ☐ 2 Present ☐ 9 Unknown/not assessed
3. Pathological reflexes — snout	☐ 1 Absent ☐ 2 Present ☐ 9 Unknown/not assessed
4. Pathological reflexes — rooting	☐ 1 Absent ☐ 2 Present ☐ 9 Unknown/not assessed
5. What is the participant's chromosome diagnosis?	☐ 1 Trisomy 21 ☐ 2 Translocation DS ☐ 3 Mosaic DS ☐ 9 Unknown/not assessed
6. What is the participant's cognitive status?	☐ 1 Cognitively stable ☐ 2 MCI-DS ☐ 3 Dementia ☐ 9 Unable to determine