SEMISTRUCTURED QUESTIONAIRE FOR TELECONSULTATION FOR FTLD PATIENTS

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START OF TELECONSULTATION (TIME)…….

PATIENT'S TELEPHONE……

DOCTOR CARRYING OUT THE TELECONSULTATION

DR……

MODE OF TELECONSULTATION

☐ Telephone ☐ Skype ☐ E-mail ☐ Others

WHO ANSWER TO THE TELECONSULTATION

- ☐ Patient
- ☐ Caregiver

NAME OF CAREGIVER……

PATIENT'S NAME AND SURNAME:……
PATIENT'S DATE OF BIRTH:……
PATIENT'S RESIDENCE: ……

PATIENT'S DIAGNOSIS:

- ☐ BvFTD
- ☐ PPA
- ☐ bvFTD plus parkinsonism
- ☐ PPA plus parkinsonism
- ☐ bvFTD plus MND
- ☐ PPA plus MND

DATE OF DIAGNOSIS …….

DATE OF ONSET DISEASE……

FIRST ACCESS DATE AT THE CENTER …….

LAST ACCESS DATE AT THE CENTER:……

Actual clinical condition of patient (globally): unchanged from the previous one?

- ☐ YES
- ☐ NO

If not than indicate the changed items*:

- ☐ A- Cognition (i.e. memory, reasoning etc)
- ☐ B- Behaviour -Psychiatric Symptoms
- ☐ C- Language
- ☐ D- Sleep disturbances
- ☐ E- Motor Function
- ☐ F- Nutritional Status
- ☐ G- Respiratory function
- ☐ H- Functional autonomy

- ☐ I - Others: _____

* *Please add details in the specific following sections if you detect changes in the clinical picture*

A) COGNITION: what domain is changed/got worse?

- ☐ Memory
- ☐ Reasoning
- ☐ Spatial orientation
- ☐ Temporal orientation
- ☐ Recognition of objects or people
- ☐ Coordination of actions (Apraxia)
- ☐ When these symptoms appeared or worsened? _____

B) BEHAVIOUR: what is changed/got worse in the clinical picture?

- ☐ Impairment of social conduct
- ☐ Apathy
- ☐ Loss of empathy
- ☐ Loss of personal hygiene
- ☐ Mental rigidity / flexibility
- ☐ Distractibility
- ☐ Dietary changes / Hyperorality
- ☐ Stereotipies / perseverations
- ☐ Aggressiveness
- ☐ Restlessness
- ☐ Anxiety
- ☐ When these symptoms appeared or worsened? _____

PSYCHIATRIC SYMPTOMS

- ☐ Visual hallucinations _____
- ☐ Auditory hallucinations_____
- ☐ Delusions _____

When these symptoms appeared or worsened? _____

Are these symptoms invalidant for patient / caregiver?

- ☐ YES
- ☐ NO

C) LANGUAGE: what is changed/got worse in the clinical picture?

- ☐ Reduced speech, reduced fluency
- ☐ Anomie
- ☐ Paraphasic errors
- ☐ Language stereotypes
- ☐ Stuttering
- ☐ Apraxia of language
- ☐ Altered repetition
- ☐ Word loss meaning
- ☐ Alteration of language understanding
- ☐ Agrammatism
- ☐ Muteness
- ☐ Alexia
- ☐ Agrafia

When these symptoms appeared or worsened? _____

D) SLEEP DISTURBANCES

Has the patient difficulty falling asleep?	☐ YES ☐ NO
Has the patient difficulty maintaining sleep?	☐ YES ☐ NO
Has the patient early awakening?	☐ YES ☐ NO
Numbers awakenings on average during the night	……..
Does the patient go back to sleep easily?	☐ YES☐ NO

Do you have restless sleep? (Kicking? Talk in sleep? Have vivid dreams that seem to be living?)

☐ YES
☐ NO

When these symptoms appeared or worsened? _____

Are these symptoms invalidant for patient /caregiver? ☐ YES ☐ NO

E) MOTOR FUNCTION: Does any item is changed/got worse? *

Please clarify the neurological symptoms/changes obtained by administering specific questions to the patient or caregiver basing on clinical experience and judgment

❖ **If motoneuron disease is present**

➢ CRANIAL NERVES:

☐ Dysarthria
☐ Dysphagia
☐ Sialorrhea
☐ Others:_____

➢ UPPER LIMBS: (UL)

- Weakness Right ☐ Left ☐
- Hypotrophy Right ☐ Left ☐
- Fasciculations Right ☐ Left ☐
- Others_____

➢ LOWER LIMBS (LL)

- Weakness Right ☐ Left ☐
- Hypotrophy Right ☐ Left ☐
- Fasciculations Right ☐ Left ☐
- Others_____

❖ **If present parkinsonism**

- Tremor at rest UL Right ☐ UL Left ☐ LL Right☐ LL Left☐ Cape/chin☐
- Muscle stiffness UL Right ☐ UL Left ☐ LL Right☐ LL Left☐ Cape☐
- Motor hindrance UL Right ☐ UL Left ☐ LL Right☐ LL Left☐

☐ Slowdown in walking

☐ Slowing down in speech
☐ Postural instability
☐ Abnormal posture of a part of the body (Specify _____)

F. NUTRITIONAL: Unchanged from the last visit?

☐ YES
☐ NO

If Not describe change

WEIGHT? ……. HEIGHT: …… BMI: ……

Does the clothes go wider than before? ☐ YES ☐ NO
Does the muscles seem thinner? ☐ YES ☐ NO
Is the patient appetizing? ☐ YES ☐ NO
How many meals he/she eat per day? ..…….

G. RESPIRATORY: Unchanged from the last visit?

☐ YES
☐ NO

If NOT describe changes
……..……..……

Has the patient dyspnea related to daily activities/at rest/lying in bed? ☐ YES ☐ NO
Has the patient bluish distal ends or bluish lips? ☐ YES ☐ NO
Does the patient complains about air hunger? ☐ YES ☐ NO
Does the patient have swollen / edematous distal ends? ☐ YES ☐ NO
Does the patient have sleepiness during the day, headache? ☐ YES ☐ NO
Tracheostomy ☐ YES ☐ NO
If Yes, date: ……..
Oxigen saturimetry at home (%value) ..……

H. SWALLOWING: Unchanged from the last visit?

- ☐ YES
- ☐ NO

If not, describe changes

Does the patient feed per OS? ☐ YES ☐ NO
Has the patient cough after swallowing? ☐ YES ☐ NO
Do liquids go sideways when the patient is drinking? ☐ YES ☐ NO
Do solids go sideways when the patient is eating? ☐ YES ☐ NO
Does the patient lack air during meals? ☐ YES ☐ NO
PEG ☐ YES ☐ NO
If Yes, date of positioning: ……..

I. FUNCTIONAL AUTONOMY

Where does patient live?

- ☐ HOME
- ☐ INSTITUTIONALIZED

If institutionalized, since when? ……..
Is the patient Assisted by a caregiver?: ☐ YES ☐ NO
Has the patient a home nursing service? ☐ YES ☐ NO

- ALSFSR:
- CDR- FTD: Sum boxes: ____Language:_____ Behaviour:_____

- Has the patient fallen from the previous visit? ☐ YES ☐ NO

If yes how many times? _____

- Is the patient bedridden? ☐ YES ☐ NO

Does the patient need some physical helps? ☐ YES ☐ NO

If yes, what kind?

- ☐ Wheelschair
- ☐ Crutches
- ☐ Codeville spring
- ☐ Cervical collar
- ☐ Walker
- ☐ Communicator

COVID-19 INFLUENCE SYMPTOMS:

Has the patient flu symptoms? ☐ YES ☐ NO

If YES, since when? _____

What kind? _____

Has the patient performed the pharyngeal swab? ☐ YES ☐ NO

If YES, date _____

Result:

- ☐ Positive for Covid-19
- ☐ Negative for Covid-19

Have the caregivers (or family relatives) flu symptoms? ☐ YES ☐ NO

If YES, since when? _____

What kind? _____

Has the caregiver (or family relatives) performed the pharyngeal swab? ☐ YES ☐ NO

If YES, date _____

Result:

- ☐ Positive for Covid-19
- ☐ Negative for Covid-19

PHARMACOLOGICA THERAPY: Is ongoing therapy changed since your last visit?

- ☐ YES
- ☐ NO

If YES specify changes:

_____

_____

- Is therapeutic plan currently ongoing? ☐ YES ☐ NO

- When it expires? _____

TELECONSULTATION CONCLUSION

THERAPY CHANGED? ☐ YES ☐ NO

IF YES, INDICATE THERAPEUTIC ADVICES PROVIDED

_____

_____

_____

HOSPITALIZATION ARRANGEMENT? ☐ YES ☐ NO

If Yes (specify)_____

_____

NEUROLOGICAL FOLLOW-UP VISIT ARRANGEMENT ☐ YES ☐ NO

If Yes (specify)_____

_____

OTHERS NOTES_____

END TIME OF TELECONSULTATION _____