MDS-UPDRS Part I: Non-Motor Aspects of Experiences of Daily Living (nM-EDL)

○ 0 of 7 completed

Form Instructions

MDS-UPDRS Instructions
The MDS-UPDRS has four parts: Part I (non-motor experiences of daily living), Part II (motor...
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Assessment Date

10/26/2020

Part IA: Complex behaviors: [completed by rater]

To be read to the patient: I am going to ask you six questions about behaviors that you may or may not experience. Some questions concern common problems and some concern uncommon ones. If you have a problem in one of the areas, please choose the best response that describes how you have felt MOST OF THE TIME during the PAST WEEK. If you are not bothered by a problem, you can simply respond NO. I am trying to be thorough, so I may ask questions that have nothing to do with you.

Primary source of information:

- ○ Patient
- ○ Caregiver
- ○ Patient and Caregiver in Equal Proportion

1.1 COGNITIVE IMPAIRMENT

Instructions to examiner: Consider all types of altered level of cognitive function including cognitive slowing, impaired reasoning, memory loss, deficits in attention and orientation. Rate their impact on activities of daily living as perceived by the

patient and/or caregiver.

Instructions to patient [and caregiver]: Over the past week have you had problems remembering things, following conversations, paying attention, thinking clearly, or finding your way around the house or in town? [If yes, examiner asks patient or caregiver to elaborate and probes for information.]

- ◯ 0: Normal: No cognitive impairment.
- ◯ 1: Slight: Impairment appreciated by patient or caregiver with no concrete interference with the patient's ability to carry out normal activities and social interactions.
- ◯ 2: Mild: Clinically evident cognitive dysfunction, but only minimal interference with the patient's ability to carry out normal activities and social interactions.
- ◯ 3: Moderate: Cognitive deficits interfere with but do not preclude the patient's ability to carry out normal activities and social interactions.
- ◯ 4: Severe: Cognitive dysfunction precludes the patient's ability to carry out normal activities and social interactions.
- ◯ Unable to Rate

1.2 HALLUCINATIONS AND PSYCHOSIS

Instructions to examiner: Consider both illusions (misinterpretations of real stimuli) and hallucinations (spontaneous false sensations). Consider all major sensory domains (visual, auditory, tactile, olfactory, and gustatory). Determine presence of unformed (for example sense of presence or fleeting false impressions) as well as formed (fully developed and detailed) sensations. Rate the patient's insight into hallucinations and identify delusions and psychotic thinking.

Instructions to patient [and caregiver]: Over the past week have you seen, heard, smelled, or felt things that were not really there? [If yes, examiner asks patient or caregiver to elaborate and probes for information.]

- ◯ 0: Normal: No hallucinations or psychotic behavior.

- ◯ 1: Slight: Illusions or non-formed hallucinations, but patient recognizes them without loss of insight.
- ◯ 2: Mild: Formed hallucinations independent of environmental stimuli. No loss of insight.
- ◯ 3: Moderate: Formed hallucinations with loss of insight.
- ◯ 4: Severe: Patient has delusions or paranoia.
- ◯ Unable to Rate

1.3 DEPRESSED MOOD

Instructions to examiner: Consider low mood, sadness, hopelessness, feelings of emptiness, or loss of enjoyment. Determine their presence and duration over the past week and rate their interference with the patient's ability to carry out daily routines and engage in social interactions.

Instructions to patient [and caregiver]: Over the past week have you felt low, sad, hopeless, or unable to enjoy things? If yes, was this feeling for longer than one day at a time? Did it mak e it difficult for you carry out your usual activities or to be with people? [If yes, examiner asks patient or caregiver to elaborate and probes for information.]

- ◯ 0: Normal: No depressed mood.
- ◯ 1: Slight: Episodes of depressed mood that are not sustained for more than one day at a time. No interference with patient's ability to carry out normal activities and social interactions.
- ◯ 2: Mild: Depressed mood that is sustained over days, but without interference with normal activities and social interactions.
- ◯ 3: Moderate: Depressed mood that interferes with, but does not preclude the patient's ability to carry out normal activities and social interactions.
- ◯ 4: Severe: Depressed mood precludes patient's ability to carry out normal activities and social interactions.
- ◯ Unable to Rate

1.4 ANXIOUS MOOD

Instructions to examiner: Determine nervous, tense, worried, or anxious feelings (including panic attacks) over the past week and rate their duration and interference with the patient's ability to carry out daily routines and engage in social interactions.

Instructions to patient [and caregiver]: Over the past week have you felt nervous, worried, or tense? If yes, was this feeling for longer than one day at a time? Did it make it difficult for you to follow your usual activities or to be with other people? [If yes, examiner asks patient or caregiver to elaborate and probes for information.]

- ◯ 0: Normal: No anxious feelings.
- ◯ 1: Slight: Anxious feelings present but not sustained for more than one day at a time. No interference with patient's ability to carry out normal activities and social interactions.
- ◯ 2: Mild: Anxious feelings are sustained over more than one day at a time, but without interference with patient's ability to carry out normal activities and social interactions.
- ◯ 3: Moderate: Anxious feelings interfere with, but do not preclude, the patient's ability to carry out normal activities and social interactions.
- ◯ 4: Severe: Anxious feelings preclude patient's ability to carry out normal activities and social interactions.
- ◯ Unable to Rate

1.5 APATHY

Instructions to examiner: Consider level of spontaneous activity, assertiveness, motivation, and initiative and rate the impact of reduced levels on performance of daily routines and social interactions. Here the examiner should attempt to distinguish between apathy and similar symptoms that are best explained by depression.

Instructions to patient [and caregiver]: Over the past week, have you felt

indifferent to doing activities or being with people? [If yes, examiner asks patient or caregiver to elaborate and probes for information.]

- ◯ 0: Normal: No apathy.
- ◯ 1: Slight: Apathy appreciated by patient and/or caregiver, but no interference with daily activities and social interactions.
- ◯ 2: Mild: Apathy interferes with isolated activities and social interactions.
- ◯ 3: Moderate: Apathy interferes with most activities and social interactions.
- ◯ 4: Severe: Passive and withdrawn, complete loss of initiative.
- ◯ Unable to Rate

1.6 FEATURES OF DOPAMINE DYSREGULATION SYNDROME

Instructions to examiner: Consider involvement in a variety of activities including atypical or excessive gambling (e.g. casinos or lottery tickets), atypical or excessive sexual drive or interests (e.g., unusual interest in pornography, masturbation, sexual demands on partner), other repetitive activities (e.g. hobbies, dismantling objects, sorting or organizing), or taking extra non-prescribed medication for non-physical reasons (i.e., addictive behavior). Rate the impact of such abnormal activities/behaviors on the patient's personal life and on his/her family and social relations (including need to borrow money or other financial difficulties like withdrawal of credit cards, major family conflicts, lost time from work, or missed meals or sleep because of the activity).

Instructions to patient [and caregiver]: Over the past week, have you had unusually strong urges that are hard to control? Do you feel driven to do or think about something and find it hard to stop? [Give patient examples such as gambling, cleaning, using the computer, taking extra medicine, obsessing about food or sex, all depending on the patient.]

- ◯ 0: Normal: No problems present.
- ◯ 1: Slight: Problems are present but usually do not cause any difficulties for the patient or

family/caregiver.

- ◯ 2: Mild: Problems are present and usually cause a few difficulties in the patient's personal and family life.
- ◯ 3: Moderate: Problems are present and usually cause a lot of difficulties in the patient's personal and family life.
- ◯ 4: Severe: Problems are present and preclude the patient's ability to carry out normal activities or social interactions or to maintain previous standards in personal and family life.
- ◯ Unable to Rate

The remaining questions in Part I (Non-motor Experiences of Daily Living) [Sleep, Daytime Sleepiness, Pain and Other Sensation, Urinary Problems, Constipation Problems, Lightheadedness on Standing, and Fatigue] are in the Patient Questionnaire along with all questions in Part II [Motor Experiences of Daily Living].

‹ Research Proxy Designation (As Needed)

MDS UPDRS Part III (No Treatment) (As Needed) ›