

OHSU BCI Sensory/Cognitive/Communication Screen, Revised

Part I: Pre-screen

To be completed with a loved one or paid caregiver who knows the participant well.

1. Participant ID #: _____ 2. Date: ____/____/____
MM DD YYYY 3. Researcher initials: _____

4. Pre-screen respondent name: _____

5. Length of relationship with participant: _____ years

6. Respondent relationship to participant:

- ☐1 Spouse/partner
- ☐2 Child
- ☐3 Parent
- ☐4 Sibling
- ☐5 Other family member
- ☐6 Friend
- ☐7 Paid caregiver

7. Can participant tolerate 1-2 hour sessions involving computer tasks? (If NO, participant is ineligible.)

- ☐1 Yes
- ☐2 No

8. Best day of week/time of day to visit? _____

Pre-screen: Communication

9. How does participant communicate? Include any and all communication methods used. _____

10. Does participant have reliable signals for "yes" and "no"?

- ☐1 Yes
- ☐2 No

11. How does participant signal "yes"? (List/describe all signals): _____

12. How does participant signal "no"? (List/describe all signals): _____

13. Do you have any concerns about participant's ability to understand spoken or written words?

- ☐1 Yes* If yes, describe: _____
 - ☐2 No
- _____

Pre-screen: Motor

14. In what position would participant be most comfortable or have the best motor response for a one hour visit?

15. Does participant need frequent repositioning?

- ☐1 Yes* If yes, describe needs:
☐2 No

16. Can participant remain in one position for 10 minutes?

- ☐1 Yes
☐2 No

17. Can participant move his/her head?

- ☐1 Yes
☐2 No

18. Can participant keep his/her head still?

- ☐1 Yes
☐2 No

19. How is participant's head supported (headrest, pillows, etc.)? _____

20. Please describe any concerns you may have about positioning or movement. _____

Pre-screen: Vision

21. Date of last eye exam: ____/____/____ ☐ Unknown ☐ No recent exam
MM YYYY

22. Clinic name and contact info: _____ ☐ Unknown/not provided

23. Does participant wear glasses?

☐1 Yes* If yes: How old are current glasses? _____ years
☐2 No How often are glasses worn? _____

24. Does participant currently take any eye medications?

☐1 Yes* If yes, please list: _____
☐2 No _____

25. Does participant have a history of any of the following?

Cataracts	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Macular degeneration	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Glaucoma	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Dry eyes/keratoconjunctivitis sicca	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Diabetes/diabetic retinopathy	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Visual field cut	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Light sensitivity	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Color blindness	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Cranial nerve injury	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY
Lazy eye	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Unknown	If yes, date of dx: ____/____/____ MM YYYY

26. Do vision problems interfere with any functional activities (e.g. watching TV, looking at a computer monitor)?

☐1 Yes* If yes, explain: _____
☐2 No _____
☐3 Unknown _____

Pre-screen: Hearing**27. Does participant have hearing loss?**

- ☐1 Yes
☐2 No
☐3 Unknown

28. Does participant wear hearing aids?

- ☐1 Yes* If yes: Which ear(s)? ☐1 Left ☐2 Right ☐3 Both
☐2 No How often? _____

29. Does participant seem to have any difficulty hearing normal conversation in a quiet room?

- ☐1 Yes
☐2 No
☐3 Unknown

Pre-screen: Cognition**30. Do you have concerns about participant's _____?**

- | | | | | |
|-------------------------|---------------------------------|-------------------------------|------------------------------------|--------------------------------------|
| Attention | <input type="checkbox"/> 1 Yes* | <input type="checkbox"/> 2 No | <input type="checkbox"/> 3 Unknown | If yes, why? _____

_____ |
| Memory | <input type="checkbox"/> 1 Yes* | <input type="checkbox"/> 2 No | <input type="checkbox"/> 3 Unknown | If yes, why? _____

_____ |
| Personality changes | <input type="checkbox"/> 1 Yes* | <input type="checkbox"/> 2 No | <input type="checkbox"/> 3 Unknown | If yes, why? _____

_____ |
| Other cognitive changes | <input type="checkbox"/> 1 Yes* | <input type="checkbox"/> 2 No | <input type="checkbox"/> 3 Unknown | If yes, why? _____

_____ |

Screening Visit Instructions

"We need to know if [participant] is taking medications that may affect his/her brain signals. Taking these medications will not exclude him/her from the study, but we do need to know about them. Please have a current medication list available for us to look at during our first visit."

"You have received/will receive a copy of the informed consent form for this study. Please read through it with the participant before our first visit. We will review it together at that time. You, or another person who knows the participant well, must sign the form as his/her authorized research representative."

Part II: Hearing, Auditory Comprehension, & Informed Consent

To be completed before participant gives consent for study involvement. First, ask participant to demonstrate his/her signals for “yes” and “no” and describe below.

31. Date: ____/____/____
MM DD YYYY

32. Researcher initials: _____

33. Signal for “yes”: _____

34. Signal for “no”: _____

35. Signal for taking a break: _____

Hearing

36. Hearing screening:

- ☐1 Pass (responds to all three frequencies in both ears)
☐2 Fail

All tones are to be presented at 25 dB. Vary pause times between tones.

“I am going to play a series of tones. Please give me your ‘yes’ signal any time you hear a tone.”

	1000 Hz	2000 Hz	4000 Hz
Right ear	<input type="checkbox"/> Response <input type="checkbox"/> No response	<input type="checkbox"/> Response <input type="checkbox"/> No response	<input type="checkbox"/> Response <input type="checkbox"/> No response
Left ear	<input type="checkbox"/> Response <input type="checkbox"/> No response	<input type="checkbox"/> Response <input type="checkbox"/> No response	<input type="checkbox"/> Response <input type="checkbox"/> No response

Communication: Auditory Comprehension

37. CRS-R: Visually Based Situational Orientation: ____/6

“Please watch what I am doing and answer my questions.”

1. Am I touching my ear right now? (do not touch ear)	N	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
2. Am I touching my nose right now? (touch nose)	Y	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
3. Am I touching my nose right now? (touch nose)	Y	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
4. Am I touching my ear right now? (do not touch ear)	N	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
5. Am I touching my nose right now? (do not touch nose)	N	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
6. Am I touching my ear right now? (touch ear)	Y	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect

38. WAB-R: Auditory Verbal Comprehension, Yes/No Questions: ____/10

"I am going ask you some questions. Please respond yes or no."

1. Is your name Brown? (NO should be correct)	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
2. Is your name [real name]?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
3. Is this a hotel?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
4. Is this your room?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
5. Are you on a roller coaster?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
6. Will paper burn in a fire?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
7. Does March come before June?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
8. Do you eat a banana before you peel it?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
9. Is a horse larger than a dog?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
10. Do you cut the grass with an ax?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect

39. BDAE: Complex Ideational Material: ____/4

"I am going to read you a short story and then I will ask you some questions about it. Are you ready?" (normal rate)

"Mr. Jones had to go to Seattle. He decided to take the train. His wife drove him to the station, but on the way they had a flat tire. However, they arrived at the station just in time for him to catch the train."

1. Did Mr. Jones miss his train?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
2. Was Mr. Jones going to Seattle?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
3. Did he get to the station on time?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
4. Was he on his way home from Seattle?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect

Informed Consent (procedures adapted from Vansteensel et al., 2016)**40. Total score for 36-38: ____/20**

If score is ≥ 19 , continue to item 40. If score is ≤ 18 , participant may be decisionally impaired. Repeat any items on which the participant had one or more incorrect responses. Repeat all questions within any repeated item, and repeat each item only once. If the participant improves to ≥ 19 on the second administration, proceed to item 40. If not, participant is ineligible for the current study.

41. Consent Form: Yes/No Questions: ____/10

Read through consent form with participant before asking these questions. If a participant answers a question incorrectly, re-read the relevant section of the consent form and ask again.

1. Will the study take 3 to 6 months to complete?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
2. Will you come to our office at OHSU?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
3. Does the study involve testing a new medication?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
4. Does the study involve testing a new typing interface?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
5. Will you wear a headband to hold electrodes on your head?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
6. Will each data collection session last 5 hours?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
7. Is there a risk of mild discomfort or eye strain?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
8. Will we make your personal data available to the public?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
9. Will you receive a \$1 gift card for each study visit?	N	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
10. Do you have the right to quit the study at any time?	Y	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect

Part III: Vision**42. Date:** ____/____/____
MM DD YYYY**43. Researcher initials:** _____**44. Corrective lenses worn during screening:**

- ☐1 Glasses
☐2 Contacts
☐3 None

Vision: Participant Report**45. Do you have trouble seeing up close?**

- ☐1 Yes
☐2 No

46. Do you have trouble seeing objects far away?

- ☐1 Yes
☐2 No

47. Do you ever have double vision?

- ☐1 Yes* If *: **43a. At near only?** ☐1 Yes ☐2 No
☐2 No **43b. With fatigue?** ☐1 Yes ☐2 No
☐3 Not sure* **43c. All the time?** ☐1 Yes ☐2 No

43d. Does it improve with one eye closed? ☐1 Yes ☐2 No ☐2 Not sure

48. Do you experience headaches or other discomfort with near-vision tasks, like using a computer?

- ☐1 Yes
☐2 No
☐3 Not sure

49. Are you bothered by light?

- ☐1 Yes
☐2 No

50. Are you bothered by glare?

- ☐1 Yes
☐2 No

Vision: Fixation

"I am going to ask you to start by looking at my nose, and then move your eyes to this target (show target) and hold your gaze there. After a few seconds I will have you look back at my nose, then at the target in another location. Look at my nose; look at the target....."

- Hold target approximately 8-10 inches from participant's face
- Using top of head, chin and either ear as reference points, start with target in center of participant's face, then move target in pattern of square.
- Participant to hold fixation on the target for at least 2 seconds. After 2 seconds, request they return their gaze to your nose and move target (eventually placing in top/bottom left/right fields).
- Note any signs of nystagmus, excessive blinking, or inability to hold fixation.

51. Participant able to hold steady gaze on target for >2 seconds: ____/4 trials

52. Observations of:

Nystagmus	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
Excessive blinking	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
Ptosis	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
Movement restrictions	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	If yes, describe: _____
Other	<input type="checkbox"/> 1 Yes*	<input type="checkbox"/> 2 No	If yes, describe: _____

Vision: Pursuits

"Watch the target as it goes around and don't take your eyes off it."

- Hold target at eye level, 16 inches from participant's face.
- Move target slowly clockwise for two rotations and counter clockwise for two rotations.
- Observe ability to keep attention on target for all rotations and accuracy of ability to follow target with smooth, accurate movements.

53. Ability:

- ☐1 Cannot complete half rotation clock or counter clockwise
- ☐2 Completes half rotation in either direction
- ☐3 Completes one rotation in either direction but not 2 rotations
- ☐4 Completes 2 rotations in one direction but less than two in other
- ☐5 Completes 2 rotations in each direction

54. Accuracy:

- ☐1 No attempt to follow target
- ☐2 Refixates 5-10x
- ☐3 Refixates 3-4x
- ☐4 Refixates 2x or less
- ☐5 No refixations

Vision: Saccades

“Next I will show you two targets. When I say “red” please look at the red target, and when I say “green” look at the green target. Please hold your gaze until I ask you to switch.”

- Position two target objects at eye level, 16 inches from participant’s face; with each target approximately 4 inches away from midline (with total separation of 8 inches between objects).
- Provide instructions
- Complete 5 rounds, for a total of 10 fixations.
- Observe ability and accuracy of eye movements.

55. Ability:

- ☐1 Completes less than 2 round trips
- ☐2 Completes 2 round trips
- ☐3 Completes 3 round trips
- ☐4 Completes 4 round trips
- ☐5 Completes 5 round trips

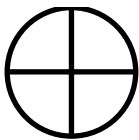
56. Accuracy:

- ☐1 Large over or undershooting is noted 1 or more times.
- ☐2 Moderate over or undershooting is noted 1 or more times.
- ☐3 Constant slight over or under shooting >50% of the time.
- ☐4 Intermittent slight over or undershooting < 50% of the time.
- ☐5 No over or undershooting noted.

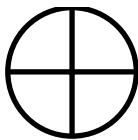
Vision: Field of Vision

“I’m going to cover one of your eyes. Look at my nose. Give me your ‘yes’ response when you see this target in your peripheral vision.”

- Slowly move target into one of four quadrants of visual field at a time.
- Repeat with other eye covered.

57. Indicate + or – for detection of target in each quadrant:

Right eye



Left eye

Vision: Distance Acuity**58. Distance acuity: 20/_____**Orientation:

- Participant to wear corrective lenses, if applicable.
- Position demo cards at eye level 8-10 inches apart in adequate lighting, approximately 20 inches from participant.
- Provide the following instructions: "Here are two cars. One has a broken wheel (point) and the other one has wheels that are okay (point)."
- Shuffle the two cards and have participant indicate the "broken" wheel, either using eye gaze or by giving a 'yes' signal when the examiner points to an option. Repeat 2-3 times to confirm understanding of instructions.

Test:

- Stand 10 feet from participant, ensuring adequate lighting on cards.
- Starting with 20/20 cards, repeat request to indicate which wheel is broken. Shuffle cards and repeat process four times.
- If 4/4 accuracy is not obtained, present additional cards in order of decreasing acuity (20/30, 20/60, etc.) until 4/4 accuracy is achieved.
- The best acuity rating at which participant achieves 4/4 accuracy should be recorded as the result.

Vision: Near Acuity**59. Near acuity: 20/_____**Orientation:

- Participant to wear corrective lenses, if applicable.
- Position demo cards at eye level, 10 inches from participant, ensuring adequate lighting.
- As previously, provide following instructions: "Here are two cars. One has a broken wheel (point) and the other one has wheels that are okay (point)."
- Rotate wheel on card and have participant indicate the "broken" wheel, either using eye gaze or by giving a 'yes' signal when the examiner points to an option. Repeat 2-3 times to confirm understanding of instructions.

Test:

- Position demo cards at eye level, 45 inches from participant, ensuring adequate lighting.
- Repeat request to have participant indicate which card has broken wheel.
- Rotate wheel of card four times. If 4/4 accuracy (indicating 20/30 acuity) is not obtained, present card at 20 inches (indicating 20/68 acuity). If 4/4 accuracy not achieved, move cards approximately 5 inches closer until 4/4 accuracy is achieved. Use variable distance chart to determine acuity.

Vision: Visual Perception

Use flipbook and answer key for this section. Complete all 5 templates for each item. Administration instructions can be found in flipbook.

59. Visual discrimination: ____/5

Template 1	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 2	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 3	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 4	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 5	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect

60. Figure ground: ____/5

Template 1	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 2	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 3	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 4	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 5	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect

61. Visual memory: ____/5

Template 1	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 2	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 3	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 4	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect
Template 5	Answer: _____	<input type="checkbox"/> Correct	<input type="checkbox"/> Incorrect

Part IV: Pain, Medications, Motor Function, Cognition, & Literacy

Use flipbook and answer key for most subtests in Part 4. Administration instructions can be found in flipbook. Provide feedback on sample items only to ensure participant understands instructions. Otherwise, provide no feedback.

62. Date: ____/____/____
MM DD YYYY

63. Researcher initials: _____

Pain**64. Do you have problems with pain?**

- ☐1 Yes* If yes, continue with questions below (using visual analogues), selected from the PROMIS Pain Interference Bank. If no, skip to question 65.
- ☐2 No

64a. In the past seven days, how difficult was it for you to take in or understand new information because of pain?

- ☐1 Not at all
☐2 A little bit
☐3 Somewhat
☐4 Quite a bit
☐5 Very much

64b. In the past seven days, how much did pain interfere with your ability to concentrate?

- ☐1 Not at all
☐2 A little bit
☐3 Somewhat
☐4 Quite a bit
☐5 Very much

64c. In the past seven days, how often was your pain so severe you could think of nothing else?

- ☐1 Never
☐2 Rarely
☐3 Sometimes
☐4 Often

- ☐5 Always

64d. In the past seven days, how often did pain make you feel discouraged?

- ☐1 Never
☐2 Rarely
☐3 Sometimes
☐4 Often
☐5 Always

64e. In the past seven days, how much did pain interfere with your ability to remember things?

- ☐1 Not at all
☐2 A little bit
☐3 Somewhat
☐4 Quite a bit
☐5 Very much

Medications

65. List participant's current medications (ALL): _____

Motor function

66. Briefly describe participant's motor function (voluntary motor abilities, involuntary movements, etc): _____

67. Note concerns and considerations regarding positioning for system trials: _____

Cognition: Trails

68. Trails A: Level 1: ☐ Pass ☐ Pass w/cues ☐ Fail
 Level 2: ☐ Pass ☐ Pass w/cues ☐ Fail ☐ Did not attempt
 Level 3: ☐ Pass ☐ Pass w/cues ☐ Fail ☐ Did not attempt

Provide as many cues as necessary for participant to successfully complete sample item for levels 1 and 2. Stop the level 2 sample item after 6 digits. If participant requires cues to complete actual test items, record those cues below. If participant fails a level, even with cues, do not attempt the next level.

Cues might include:

1. Show and say current number, then ask "What comes next?"
2. Show and say current number, then show and say next number and ask participant to look at it.

Write box numbers for participant's responses in order, then check against answer key.

Level	Responses						Cues provided (if applicable)
1							
2							
3							

69. Trails B: **Level 1:** ☐ Pass ☐ Pass w/cues ☐ Fail
Level 2: ☐ Pass ☐ Pass w/cues ☐ Fail ☐ Did not attempt

Provide as many cues as necessary for participant to successfully complete sample items. Stop the level 2 sample item after 6 digits/letters. If participant requires cues to complete actual test items, record those cues below. If participant fails a level, even with cues, do not attempt the next level.

Cues might include:

1. Show and say current number, then ask "What comes next?"
2. Show and say current number, then show and say next number and ask participant to look at it.

Write box numbers for participant's responses in order, then check against answer key.

Level	Responses						Cues provided (if applicable)
1							
2							

Literacy

70. Concept of print: Letter: ____ correct/ ____ administered

Word: ____ correct/ ____ administered

Sentence: ____ correct/ ____ administered

Write box numbers for participant's responses, then check against answer key.

	Letter	Word	Sentence
Template 1	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.
Template 2	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.
Template 3	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.
Template 4	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.
Template 5	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.	A: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Inc.

71. Letter identification: ____ correct/____ administered

Write box numbers for participant's responses, then check against answer key.

Template 1	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 2	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 3	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 4	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 5	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect

72. Copy-spelling: ____ correct/____ administered

Write box numbers for participant's responses in order, then check against answer key.

Template 1				<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 2				<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 3				<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 4				<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 5				<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect

73. Error awareness: ____ correct/____ administered

Write box numbers for participant's responses, then check against answer key.

Template 1	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 2	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 3	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 4	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect
Template 5	Answer: ____ <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect

Reference List

The OHSU BCI Sensory/Cognitive/Communication Screen, Revised includes items adapted from the following instruments:

- Boston Diagnostic Aphasia Examination: Goodglass H, Kaplan E, Barresi B. BDAE-3: Boston Diagnostic Aphasia Examination—Third Edition. Philadelphia, PA: Lippincott Williams & Wilkins; 2001.
- Broken Wheel Tests: Richman JE, Petito GT, Cron MT. Broken wheel acuity test: a new and valid test for preschool and exceptional children. Journal of the American Optometric Association. 1984 Aug;55(8):561-5.
- Coma Recovery Scale-Revised: Giacino JT, Kalmar K, Whyte J. The JFK Coma Recovery Scale-Revised: measurement characteristics and diagnostic utility. Archives of physical medicine and rehabilitation. 2004 Dec 1;85(12):2020-9.
- Motor-Free Visual Perception test: Colarusso RP, Hammill DD. Motor-Free Visual Perception Test. Academic Therapy Pub; 1972.
- NSUCO Oculomotor Test: Ficklin IT, Maples WC, Atchley J. Northeastern State University College of Optometry's Oculomotor Norms. J Behav Optom. 1992;3:143–150.
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About This Instrument

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