ACE-R

Frequently asked questions

**Why do I have to register to download the tests?**
We would like to keep all users informed of any changes and updates on the tests, normative data, and relevant papers. We are also interested in keeping a register so that we can track how widely used the instrument has become.

**Why are there 3 different versions (A, B and C)?**
The versions differ in terms of the name and address recall task. They were designed to avoid learning from one assessment to the next. Some patients may learn the name and address over a couple of years follow-up, making the test invalid.

**When can I re-assess someone with the ACE-R?**
Ideally only after 6 months (not earlier), to prevent patients from recalling components for the test.

**Can I make a dementia diagnosis based on the ACE-R score?**
No. The ACE-R score should be only part of your clinical assessment, but never used solely for a diagnosis. If your patient has a low score (e.g. below cut-off), you might consider referring them for a thorough neuropsychological assessment, or to a specialist if dementia/cognitive decline has not been raised yet. It is important to remember that low scores can also be due to low
levels of education, cultural background differences or depression. Although, in our experience, such factors rarely produce a score below 82.

**Can I rate dementia (e.g. mild, moderate and severe) with an ACE-R score?**

No. Dementia ratings involve a comprehensive evaluation and should be arrived at after via a thorough clinical assessment involving information from caregivers and family members, and taking into account activities of daily living. We are currently looking at its value in rating dementia severity across different disorders.

**Can any health professional give the ACE-R?**

Yes. We recommend you to read the ACE-R guidelines, these frequently asked questions, and to practise administration with a few controls (friend, parent, grandparent, etc) to familiarise yourself with the test.

**Do I need to pay to use the ACE-R?**

No. Prof John Hodges holds the ACE-R copyright, but welcomes everyone to use it for clinical and research purposes.

**Are there normative data for patients above 75?**

Not at the moment. Our collaborators are currently collecting extended normative data, and we will update all registered users once the norms are established.
**Can I validate the ACE-R in my country?**

If your language/country is not listed in our website, please contact us to get some background information and authorisation to translate and validate the test.

**Can I ask for the name of the building where the clinic/rehabilitation ward/outpatient service etc is based, instead of floor?**

Yes. Sometimes it does not make sense to ask for the floor, so a reasonable adaptation is welcome. Just make sure your team asks the question in the same way, and try to make notes of any changes you might have made for follow-up re-assessments.

**Which scores should I use for the VLOM ratio?**

\[ VLOM = \frac{\text{Verbal fluency} (\text{max 14}) + \text{Language} (\text{max 26})}{\text{Orientation} (\text{max 10}) + \text{Memory} (\text{max 7})} \]

Orientation = only two first tasks

Memory = only recall of name and address at the end of the test

**Can I apply the semantic index on the ACE-R?**

Not directly. The analyses were done using the old ACE, so if you are interested in using the index, you should complement the ACE-R with the questions that make the semantic index to generate the scores you need.
**I use the “old” ACE; should I change to the revised ACE (ACE-R)?**

Ideally, yes. After years of use in Cambridge, John Hodges and his team identified many weaknesses on the test, and the revised version was produced and validated.

**What are the key references on the use of the ACE and ACE-R?**

**ACE**


ACE-R