Diabetes Prevention Program

PREGNANCY CONFIRMATION REPORT

This form is to be completed if the participant has had a positive pregnancy test.

Part I / IDENTIFICATION

A. Participant Identification

1. Clinic number ☐☐ CLINIC
2. Participant number ☐☐☐☐☐☐ PATID
3. Participant's initials ☐☐☐☐ INITS (first last)
4. Participant's date of birth ☐☐ ☐☐ ☐☐ DOB (month day year)

B. Report Identification

1. Date of report ☐☐ ☐☐ ☐☐ DORPTDT (month day year)

C. Instructions for Form E04 Completion

Complete all sections of Form E04 if the participant is assigned to pharmacological treatment. If the participant is assigned to Intensive Lifestyle Intervention, complete up to and including question D.3.

Initials of person reviewing completed form ☐☐☐☐ (first last) Form entered in computer? ☐

D. Pre-natal

1. Date of positive pregnancy test (month day year) — DOTSTDT replaced with DAYSPREG

2. Estimated date of delivery (month day year) — DOEDD replaced with DAYEDD

3. Name/Address/Phone of Obstetric care provider:

_____

_____

_____

_____

If participant is assigned to pharmacological treatment, continue.

4. Was this a planned pregnancy? YES [1] NO [2] — DOPLAN

If YES,

a. Was coded metformin discontinued prior to conception? YES [1] NO [2] — DODISA

b. Metformin stop date (month day year) — DODISCA replaced with DAYSMETS_PRIOR

NOTE; THESE VARIABLES ALSO INCLUDE TROGLITAZONE

If NO,

c. Has coded metformin been discontinued? YES [1] NO [2] — DODISB

d. Metformin stop date (month day year) — DODISCB replaced with DAYSMETS_AFTER

5. Does participant wish to continue pregnancy? YES [1] NO [2] — DOCONT

6. Was coded metformin unmasked? [1] [2] — DOBLIND