

Diabetes Prevention Program

SCREENING STEP 2 INVENTORY

This form is completed during Screening Step 2.
 Form S03 records the following: BMI, arm blood pressures, urinalysis, current medications, and pregnancy/diabetes information; OGTT qualification, progression and local results; demographics and complete blood count (CBC) results.

Part I / IDENTIFICATION

A. Participant Identification

1. Clinic number

CLINIC

2. Screening number

SCREEN

3. Participant's initials

INITS

first last

4. Participant's date of birth

month	day	year	

DOB

If age is \geq 25 years continue, if age < 25 years, STOP. Fill in Eligibility Checklist item C.1.

5. Participant's sex

Male

Female

SEX

B. Visit Information

1. Date of visit

month	day	year	

SOVSTDT

C. Instructions for Form S03 Completion

Prior to the OGTT procedure, complete all of sections D through J of Form S03 unless a STOP is encountered. Sections K and L should be completed during the OGTT procedure. The remaining sections, M through O, should be completed during or after the OGTT procedure.

Initials of person reviewing completed form

first last

Form entered in computer?

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

Part II / BEFORE OGTT

D. BMI

1. Height

a. First measurement

			.	
--	--	--	---	--

cm

SOHGHT1

b. Second measurement

			.	
--	--	--	---	--

cm

SOHGHT2

Record c. only if first 2 measurements are not within 0.5 cm .
--

c. Third measurement

			.	
--	--	--	---	--

cm

SOHGHT3

2. Weight

a. First measurement

			.	
--	--	--	---	--

kg

SOWGHT1

b. Second measurement

			.	
--	--	--	---	--

kg

SOWGHT2

Record c. only if first 2 measurements are not within 0.2 kilogram (200 gm).
--

c. Third measurement

			.	
--	--	--	---	--

kg

SOWGHT3

3. Is BMI $\geq 24 \text{ kg/m}^2$ ($\geq 22 \text{ kg/m}^2$ for Asians)?

YES

NO

1

2

SOBMI

Use largest height and smallest weight for eligibility. See chart.
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If BMI is $\geq 24 \text{ kg/m}^2$ ($\geq 22 \text{ kg/m}^2$ for Asians) continue, if BMI $< 24 \text{ kg/m}^2$ ($< 22 \text{ kg/m}^2$ for Asians) STOP. Fill in Eligibility Checklist item C.3

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

E. Blood Pressure

1. Seated Arm Blood Pressure

a. Blood Pressure Reading 1
(after sitting 5 minutes)

Systolic	Diastolic
SOSBP1	SODBP1
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
mmHg	

b. Blood Pressure Reading 2
(after waiting 30 seconds)

SOSBP2	SOSBP2
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
mmHg	

c. Average of 1.a & 1.b
(round up)

SOSBPA	SODBPA
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
mmHg	

If average SBP \leq 180 mmHg and average DBP \leq 105 mmHg, continue.
If SBP > 180 mmHg or DBP > 105 mmHg, STOP.
Fill in Eligibility Checklist item D.3.e

F. Urinalysis

	negative	trace	1+	2+	3+	4+	
1. Protein:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SOPRTN
	negative	positive					
2. Nitrite:	<input type="text"/>	<input type="text"/>	SONTRT				
	negative	trace	1+	2+	3+		
3. Blood:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SOB	

If urine protein < 2+, continue. Repeat urine dipstick later if protein is 2+ or greater AND nitrite is positive or blood is 1+ or greater, continue with form. If urine protein is 2+ or greater and nitrite is negative and blood is <1+ , STOP.
Fill in Eligibility Checklist item D.5.b.

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

G. Current Medications

1. Has the participant taken any PRESCRIPTION medications within the past 2 weeks?

YES

NO

SORXDQ

If YES, list below - confirm by inspection of bottles:

	Medicine Description	Route
a.	SORXDA1	
b.	B1	
c.	C1	
d.	D1	
e.	E1	
f.	F1	
g.	G1	
h.	H1	
i.	I1	
j.	J1	

check dose if SSRI
(Prozac, Paxil, Zoloft, Luvox)

2. Are any of these medications exclusionary?

YES

NO

SORSEX

Fill in Eligibility Checklist items G.1 - 9. Participant may be eligible if medication can be discontinued.

H. Pregnancy (Women < 50 years only)

1. Are you currently pregnant or nursing a baby?

YES

NO

MAYBE

SOPREG

If YES, STOP. If MAYBE, probe further and do pregnancy test. If not pregnant, continue.
Fill in Eligibility Checklist items E.10.a & b.

I. Diabetes

1. Have you ever been told that you had a high sugar level or that you have diabetes?
(women: including during pregnancy)

check only one

No

Only during pregnancy

Yes, borderline

Yes

SODIAB

If YES, and can confirm with physician, or medication, STOP. If otherwise, continue.
Fill in Eligibility Checklist item F.1.a.

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

Part III / SCREENING OGTT

J. Test Qualification

1. Have you been ill in the past 7 days (e.g. cold, flu, fever, vomiting)?

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	SOILL

If YES, cancel current OGTT and reschedule.

2. What time and date did you last eat or drink anything other than water?

a. Date

month	day	year

SOEATD

b. Time

	:	
time (24 hour clock)		

SOEATT

If < 12 hours, cancel and reschedule the OGTT.

3. Have you eaten your typical or usual diet over the past 3 days?

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	SODIET

If NO, cancel and reschedule the OGTT if markedly less than usual caloric intake.

4. When was the last time you exercised vigorously?

a. Date

month	day	year

SOEXED

b. Time

	:	
time (24 hour clock)		

SOEXET

If < 10 hours, cancel and reschedule the OGTT.

Perform local fasting capillary or venous glucose. Record results in Section L of Form S03 - Local OGTT Results.

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

K. Test Progression

1. Were the fasting blood samples drawn? (i.e., local CBC and CBL specimens) YES NO SOFAST

2. Time glucose consumption started : SODRKT
time (24 hour clock)

If drink not entirely consumed within 5 minutes, cancel and reschedule the OGTT.

3. Time 30 minute sample drawn : SO30MT
time (24 hour clock)

The sample should be drawn within 2 minutes of the 30 minute interval. If the sample is drawn outside that window record the time and continue with the OGTT.

4. Time 2-hour sample drawn : SO2HRT
time (24 hour clock)

The sample must be drawn within 10 minutes of the 2 hour interval with a goal of ± 5 minutes. If the blood sample can not be obtained within the 10 minute window, the test must be rescheduled.

Perform local 2-hour capillary or venous glucose. Record results in Section L of Form S03 - Local OGTT Results.

5. The OGTT was (choose only one): completed **without** problem SORESL
completed **with** problem
not completed

a. Why was OGTT "completed with problem" or "not completed"? Vomited after glucose load SOFAIL
Fainted or felt ill after glucose load
Blood sample not obtained within the 10 minute window of 2-hour blood draw
Participant did not drink entire glucose load in 5 minutes
Participant not eligible based on local fasting glucose
Other (specify below)

Other Specified: _____

Participant's initials

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
first	last		

Date of birth

<input type="text"/>	<input type="text"/>	<input type="text"/>
month	day	year

Date of visit

<input type="text"/>	<input type="text"/>	<input type="text"/>
month	day	year

L. Local OGTT Results

1. Fasting glucose

a. What method was used to draw the blood?

Capillary	<input type="text"/>
Venous	<input type="text"/>

SOLMETH

b. What machine was used to analyze the blood?

Lifescan	<input type="text"/>
Glucose analyzer	<input type="text"/>

SOLMACH

i. If Glucose analyzer was selected specify:

Beckman	<input type="text"/>
YSI	<input type="text"/>
Other	<input type="text"/>

SOLSPEC

c. Fasting glucose level

<input type="text"/>	<input type="text"/>	<input type="text"/>
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mg/dL SOLFAST

2. 2-hour glucose

a. What method was used to draw the blood?

Capillary	<input type="text"/>
Venous	<input type="text"/>

SOLMTH2

b. What machine was used to analyze the blood?

Lifescan	<input type="text"/>
Glucose analyzer	<input type="text"/>

SOLMCH2

i. If Glucose analyzer was selected specify:

Beckman	<input type="text"/>
YSI	<input type="text"/>
Other	<input type="text"/>

SOLSPC2

c. 2 - hour glucose level

<input type="text"/>	<input type="text"/>	<input type="text"/>
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mg/dL SOL2HR

If eligible based on local glucose, send all samples to Central Biochemistry Lab. If not eligible based on local glucose, STOP; participant may be rescreened in 6 months.
Complete Eligibility Checklist items C.2.a & b.

3. Is participant eligible based on local glucose?

YES	NO
<input type="text"/>	<input type="text"/>

SOL2HR

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

Part IV / DURING OR AFTER OGTT

M. Demographics

1. What ethnic or racial group do you consider yourself a member: (*check only one*)

- White. 1 SOETHN
- Black. 2
- American Indian or Native American. 3 (specify principal tribe: _____)
- Eskimo. 4
- Aleut. 5
- Asian or Pacific Islander. 6
- Other. 7 (specify: _____)

If ASIAN OR PACIFIC ISLANDER (response = 6 above)

a. Specify: (*check only one*)

- Chinese. 1
- Filipino. 2 SOASN
- Hawaiian. 3
- Korean. 4
- Vietnamese. 5
- Japanese. 6
- Asian Indian. 7
- Samoan. 8
- Guamanian. 9
- Other A/PI. 10 (specify: _____)

2. Are you of Spanish or Hispanic origin? YES 1 NO 2 SOHSP

If YES,

a. Do you consider yourself:

- Mexican, Mexican-American, Chicano 1
- Puerto Rican 2 SOHSPS
- Cuban 3
- Other Spanish or Hispanic 4

specify: _____

Participant's initials

first		last	

Date of birth

month	day	year

Date of visit

month	day	year

Part V / LOCAL LABORATORY RESULTS

N. Complete Blood Count

1. Hemoglobin

		.	
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g/dL

SOHGLOB

2. Hematocrit

		.	
--	--	---	--

%

SOHCRT

Participant is ineligible if <36.0% for men, <33.0% for women. Fill out Eligibility Checklist item D.8.

3. Platelet Count

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x10³/ml

SOAGRAN

Part VI / CONTINUING SCREENING

O. Eligibility/Interest

1. Is participant willing to continue with screening process

YES

NO

1

2

SOWILL

If YES, schedule participant for Screening Step 3 visit. If NO, STOP. Fill in Eligibility Checklist item E.1.
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