Today's Date: ___/___/___ (MM/DD/YY)

DIABETES PREVENTION TRIAL - TYPE 1 (DPT-1)
ICA SCREENING FORM

This form provides important data to be used to identify persons at risk for insulin dependent diabetes mellitus (IDDM). Do not proceed with screening if you already have IDDM. Authority to collect information on this form is contained in Title 42 of the U.S. Code, Sections 242(a) and 285(c). The primary use of this information is for research on diabetes mellitus. Your provision of this information is voluntary. Disclosure of your social security number is voluntary and is requested to assist in efforts to locate you in the future. Information you provide will not be disclosed in a manner that identifies you without your consent to anyone outside of authorized users, except as permitted by the Privacy Act.

PERSON BEING SCREENED:

Name: _____ , _____ _____
Last First MI

Address: _____

City: _____ State or Province: _____ ZIP: _____

Country: _____

Telephone: Daytime (___) _____ Evening (___) _____ FAX (___) _____

Birthday: ___/___/___ (MM/DD/YY) Age: ____ Sex: ____ F=Female M=Male Race: ____

W=White, not of Hispanic origin
B=Black, not of Hispanic origin
H=Hispanic
A=American Indian/Alaskan Native
O=Asian/Pacific Islander
X=Other

Social Security Number (optional): ___ - ___ - _____

SAMPLE INFORMATION: Date blood sample drawn: ___/___/___ (MM/DD/YY) Local lab # (if applicable): _____

(NOTE: USE THIS FORM ONLY FOR YOUR *FIRST* DPT-1 SCREENING, NEVER FOR RESCREENING)

Have you ever been tested for Islet Cell Antibodies (ICA) prior to the DPT-1? ❑ Yes ❑ No ❑ Don't know

If yes, where? _____

RELATIVES WITH INSULIN-DEPENDENT DIABETES (IDDM):

For "Type of Relative" use: M=Mother F=Father Son=Son D=Daughter B=Brother Sis=Sister X=Other (Specify _____)

Type of Relative	Age developed IDDM	Date developed IDDM (MM/YY)	Age insulin treatment began
_____	_____	____ / ____	_____
_____	_____	____ / ____	_____
_____	_____	____ / ____	_____
_____	_____	____ / ____	_____

PEOPLE TO BE NOTIFIED OF SCREENING RESULTS:

❑ Person screened (only) ❑ Screening physician (only) ❑ Person screened PLUS screening physician

SCREENING PHYSICIAN: Name: _____

Address: _____

City: _____ State or Province: _____

ZIP: _____ Country: _____

Phone: (___)_____ FAX: (___)_____

CLINICAL CENTER: A clinical center will be responsible for study follow-up. If you have a preference for a particular center, please check the appropriate box below. If you have no preference, leave the boxes blank and a center will be assigned.

❑ 1 University of Florida (Gainesville, FL) Desmond Schatz, MD
❑ 3 LAC-USC Medical Center (Los Angeles, CA) Adina Zeidler, MD
❑ 4 Children's Hospital of LA (Los Angeles, CA) Francine R. Kaufman, MD
❑ 5 Stanford University (Stanford, CA) Darrell Wilson, MD
❑ 6 University of Miami (Miami, FL) Jennifer Marks, MD
❑ 7 Barbara Davis Center (Denver, CO) H. Peter Chase, MD
❑ 8 Joslin Diabetes Center (Boston, MA) Joseph Wolfsdorf, MD / Alyne Ricker, MD
❑ 9 University of Minnesota (Minneapolis, MN) David Brown, MD
❑ 10 University of Washington (Seattle, WA) Carla Greenbaum, MD

HOW DID YOU HEAR ABOUT THE DPT-1 TRIAL ?

❑ Existing DPT-1 Site ❑ Physician ❑ 1(800) HALT-DM1 ❑ Meeting/Presentation ❑ Family/Friend
❑ Newspaper/Magazine ❑ Radio/TV ❑ Poster ❑ Other: (Specify) _____

ICA Reference Laboratory Use Only

ID# _____ Study #: 9401 Sample #: _____ Physician ID #: _____ Date Rcvd: _____

Please allow 12-16 weeks for notification of results