EPIDEMIOLOGY OF DIABETES INTERVENTIONS AND COMPLICATIONS
ANS Testing Eligibility

Complete this form prior to ANS testing.

If submitting studies electronically via FTP server, fax a copy of this form and form 59 to the Autonomic Reading Center (ARC) at Mayo. If submitting studies via CD, send this form and form 59 along with the CD to the ARC. Send a copy of this form to the Coordinating Center in your monthly mailing. Retain an electronic copy of the ANS study within the clinic. Document all submissions to the ARC using form 59 OR via standard web-based tracking (when available). Make sure to add Patient ID Number, EDIC Year, and Form Date to the top and bottom of page 2 and 3.

A. IDENTIFYING INFORMATION

1. Clinic Number: __ __
2. Patient ID Number: __ __ __ __ __
3. Patient's Initials: __ __ __
4. Date Form Completed: __ __/__ __/__ __
   Month Day Year
5. EDIC Follow-Up Year? __ __

	No	Yes
6. Is this subject a normal control?	(1)	(2)
7. Is this testing being performed for ANS certification?	(1)	(2)

B. PREPAREDNESS FOR TESTING

If YES is answered to any of the questions below, patient is ineligible for ANS testing today. Reschedule the patient for testing another day and discard this form.

	No	Yes
1. Any food since midnight?	(1)	(2)
2. Any liquids (except water) since midnight?	(1)	(2)
3. Any caffeine since midnight?	(1)	(2)
4. Any medication since midnight (excluding basal pump insulin)?	(1)	(2)
5. Any over-the-counter drugs since midnight (aspirin, antihistamines, nasal spray, etc)?	(1)	(2)
6. Any alcohol in the last 24 hours?	(1)	(2)
7. Any tobacco since midnight?	(1)	(2)
8. Any vigorous exercise in the last 24 hours? (Any exercise not part of patient's daily routine, i.e., routine jogging is O.K., but marathon running is not. NO exercise morning of test.)	(1)	(2)
9. Any emotional upset in the last 24 hours? (Depression, crying episodes, anxiety from personal trauma [death, divorce, car accident, dentist, etc.])	(1)	(2)
10. Acute illness in last 48 hours? (cold, flu, measles, etc).	(1)	(2)
11. Any hypoglycemic episodes since midnight?	(1)	(2)

12. a) Fasting blood sugar value (finger stick method is O.K.) __ __ __ mg/dl

	No	Yes
b) Below 50 or signs or symptoms of hypoglycemia?	(1)	(2)

C. PHYSICAL CONDITION

1. Height (cm) __ __ __.__
2. Weight (kg) __ __ __.__
3. List any medications taken in the past 48 hours:

_____

_____

D. BLOOD PRESSURES

1. R-R (Subject is supine for all R-R blood pressures)

a. Immediately prior to R-R	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___
b. Immediately after R-R	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___

2. Postural Study (Subject is standing for all postural study blood pressures)

0 minute	Instruct patient to stand	
a. 1 minute	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___
b. 2 minute	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___
c. 3 minute	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___
d. 4 minute	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___
e. 5 minute	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___
f. 10 minute	i. systolic (mm Hg)	___ ___ ___
	ii. diastolic (mm Hg)	___ ___ ___

3. Did postural hypotension occur(a drop of at least 10 mm Hg in diastolic blood pressure AND obvious signs and symptoms)?

No (1) Yes(2)

4. If yes, approximately how many minutes into the test did the postural hypotension occur?

___ ___ minutes

E. TEST SUMMARY

1. Was the R-R portion of the test completed?

No (1) Yes(2)

If no, why not?

_____

_____

2. Was the Postural Study completed?

No (1) Yes(2)

If postural study not completed for ANY REASON OTHER THAN POSTURAL HYPOTENSION, specify:

_____

_____

3. Enter number of Valsalva studies **attempted** (enter “0” if no Valsalva studies were attempted).

_____

4. Enter number of Valsalva studies **completed** (enter “0” if no Valsalva studies were completed).

_____

5. If the number listed in E4 is less than 2, select the most appropriate reason from the list below(check only 1):

a. Subject with PDR, hx of LASER or Vitrectomy (1)

b. Subject with suspected (unconfirmed) PDR (1)

c. Subject couldn’t adequately perform blowing (1)

d. Other (Specify): _____ (1)

_____

Type or print name of person completing this form: Certification Number (if any)

_____ __ __ - __ __

Include any additional comments related to test performance on Page 3 and submit to the ANS reading center.

COMMENTS: Check here if no comments (1)

Type or print name of person completing this form:

Certification Number (if any)

_____ __ __ - __ __