EPIDEMIOLOGY OF DIABETES INTERVENTIONS AND COMPLICATIONS

Health Care Delivery Questionnaire

INSTRUCTIONS:

- The information requested pertains to the past 12 months.
- Evaluations performed as part of the EDIC evaluation should NOT be included in the answers requested.

A. IDENTIFYING INFORMATION

Clinic 1. Clinic Number: ✓ | 5. Form Date 4. Date Form Completed: ✓ ___/___/___ Month Day Year

Patient 2. Patient ID Number: ✓ ________ (5)

Initials 3. Patient's Initials: ✓ | 6. Edic Year 5. EDIC Year: ✓ ___ (2)

B. HEALTH CARE INSURANCE COVERAGE

		YES	NO	UNCERTAIN
G0B1	1. In the past 12 months, was there any time that you did not have health insurance coverage? **If "no", go to item #4a.**	(1)	(2)	(3)
G0B2	2. If "yes" to item #1, how long were you without coverage?	___ months		
G0B3	3. Currently, do you have health insurance coverage?	(1)	(2)	(3)

G0B4A 4a. If you have had any health insurance coverage in the past 12 months, what is the name(s) of your plan(s)? If you have had coverage with more than one company, please list them all. $40 ________________

4b. If you have had any health insurance coverage in the past 12 months, what type(s) have you had? (CHECK ALL THAT APPLY.)

G0B4BA	a. Indemnity or fee-for-service plan (i.e. you choose which doctor you see for care without financial penalty)	(1)
G0B4BB	b. Health Maintenance Organization (HMO) (i.e. you must have a primary care physician who must refer you to specialty care if needed)	(2)
G0B4BC	c. Preferred Provider Organization (PPO) (i.e. you have lower co-payments when you see a preferred provider within the network, but can see a provider out-of-network for a higher co-payment)	(3)
G0B4BD	d. Point of Service (POS) (i.e. you must have a primary care provider; you have the option to self-refer to in-network specialist, or you can see out-of-network specialist with higher co-payment)	(4)

4c. If you have had any health insurance coverage in the past 12 months, how would you describe your insurance plan(s)? (CHECK ALL THAT APPLY.)

G0B4CA	a. An individual plan - the member pays for the plan premium	(1)
G0B4CB	b. A group plan through an employer, union, etc. - the employer pays all or part of the plan premium	(2)
[illegible]B4CC	c. A government plan - the government pays for the plan premium	(3)
[illegible]B4CC1	1. U.S. Government Health Plan (i.e. Military, CHAMPUS, VA)	(4)
G0B4CC2	2. Canadian Government Plan	(5)
G0B4CC3	3. Medicaid ✓	(6)
G0B4CC4	4. Medicare	(7)

5. If you **currently** have health insurance, does it provide coverage (complete coverage or partial coverage after co-payments or deductibles) for any of the following:
(If you do not currently have health insurance, go to Section C.)

			YES	NO	UNCERTAIN
G0B5A	a.	Medical visits for diabetes (medical doctor, doctor of osteopathy)	(1)	(2)	(3)
G0B5B	b.	Medical visits for diabetes (nurse practitioner, physician assistant)	(1)	(2)	(3)
G0B5C	c.	Insulin	(1)	(2)	(3)
G0B5D	d.	Syringes	(1)	(2)	(3)
G0B5E	e.	Blood glucose testing strips	(1)	(2)	(3)
G0B5F	f.	Blood glucose testing meters	(1)	(2)	(3)
G0B5G	g.	Glucose tablets	(1)	(2)	(3)
G0B5H	h.	Glucagon	(1)	(2)	(3)
G0B5I	i.	Insulin infusion pump	(1)	(2)	(3)
G0B5J	j.	Insulin infusion pump supplies	(1)	(2)	(3)
G0B5K	k.	Glycosylated hemoglobin or HbA_1C test	(1)	(2)	(3)
G0B5L	l.	Fructosamine test (blood test like HbA_1C that reflects past 2-3 weeks blood sugar levels)	(1)	(2)	(3)
B5M	m.	Blood tests (in general)	(1)	(2)	(3)
G0B5N	n.	Urine tests (in general)	(1)	(2)	(3)
G0B5O	o.	Electrocardiograms (EKG)	(1)	(2)	(3)
G0B5P	p.	Cardiovascular stress tests	(1)	(2)	(3)
G0B5Q	q.	Dilated eye exams	(1)	(2)	(3)
G0B5R	r.	Eye photos	(1)	(2)	(3)
G0B5S	s.	Laser treatment for eyes for diabetic retinopathy / macular edema	(1)	(2)	(3)
G0B5T	t.	Dialysis (in-home or outpatient)	(1)	(2)	(3)
G0B5U	u.	Nutrition counseling	(1)	(2)	(3)
G0B5V	v.	Diabetes education services	(1)	(2)	(3)
G0B5W	w.	Services of mental health professionals	(1)	(2)	(3)
G0B5X	x.	Emergency room visits	(1)	(2)	(3)
G0B5Y	y.	Walk-In clinics or urgent care center visits	(1)	(2)	(3)
G0B5Z	z.	Hospitalization due to diabetes related complications	(1)	(2)	(3)
B5AA	aa.	Hospitalization for other health issues	(1)	(2)	(3)
5BB	bb.	Nursing home care, convalescent care, or rehabilitation care	(1)	(2)	(3)
G0B5CC	cc.	Home health care services	(1)	(2)	(3)

C. HEALTH CARE PROVIDERS AND SOURCES OF CARE

1. Where do you usually go to receive **DIABETES** health care services? (CHECK ONLY ONE (1) LOCATION.)

GOC1A a. Doctor's private office GOC1 (1)
GOC1B b. Outpatient general medical clinic GOCOTH1 $40 (1)
GOC1C c. Outpatient diabetes clinic (1)
GOC1D d. Company clinic (1)
GOC1E e. Walk-In clinic or urgent care center (1)
GOC1F f. Hospital emergency room (1)
GOC1G g. The EDIC annual evaluation is your only source of diabetes health care (1)
GOC1H h. Other, specify: 59. GOC1H1 (1)
GOC1I i. There is no single location where you usually go for health care. (1)

2. Who currently provides your **DIABETES** health care at this location? (CHECK ONLY ONE (1) PROVIDER.)

GOC2A a. Generalist (general practitioner, family practitioner, internist, or nurse, nurse practitioner, physician assistant working with a generalist) GOC2 GOCOTH2 $40 (1)
GOC2B b. Specialist (diabetologist, endocrinologist, or nurse, nurse practitioner, physician assistant working with a diabetologist or endocrinologist) (1)
GOC2C c. Other, specify: 64. GOC2C1 (1)
GOC2D d. None. You have no current health care provider. (1)

3 3. Is the diabetes provider checked in item #2 a member of the DCCT staff or a current member of the EDIC staff? GOC3

YES	NO
(1)	(2)

4. Where do you usually go to receive **GENERAL** health care services? (CHECK ONLY ONE (1) LOCATION.)

GOC4A a. Doctor's private office GOC41 (1)
GOC4B b. Outpatient general medical clinic (1)
GOC4C c. Outpatient diabetes clinic (1)
GOC4D d. Company clinic (1)
GOC4E e. Walk-In clinic or urgent care center (1)
GOC4F f. Hospital emergency room (1)
GOC4G g. The EDIC annual evaluation is your only source of general health care. (1)
GOC4H h. There is no single location where you usually go for health care. (1)

5. Who currently provides your **GENERAL** health care at this location? (CHECK ONLY ONE (1) PROVIDER.)

GOC5A a. Generalist (general practitioner, family practitioner, internist, or nurse, nurse practitioner, physician assistant working with a generalist) GOC51 GOCSOTH1 $40 (1)
GOC5B b. Specialist (diabetologist, endocrinologist, or nurse, nurse practitioner, physician assistant working with a diabetologist or endocrinologist) (1)
GOC5D d. Other, specify: 48. GOC5D1 (1)
C5E e. None. You have no current health care provider. (1)

GOC6 6. Is your general health care provider the same person who provides your diabetes health care?

YES	NO
(1)	(2)

		YES	NO	# OF VISITS
GOC7	7. In the past 12 months, have you visited your EDIC clinic for health care services unrelated to the EDIC study?	(1)	(2)	82. GOC71
GOC8	8. In the past 12 months, have your EDIC annual evaluations been the only health care services you have received?	(1)	(2)	
GOC9	9. In the past 12 months, what percentage of your diabetes health care has been provided by your EDIC evaluation? (0% = None, 100% = All)			___ ___ ___ % (5)

10. Please indicate if you have had any visits in the past 12 months to any of the providers listed below. For each "yes" response record the number of visits in the past 12 months. **(Do not include EDIC evaluations in response to this question. Include outpatient visits only.)**

	Health Care Provider	YES	NO	# OF VISITS
GOC10A	a. Generalist visit (general practitioner, family practitioner, internist, or nurse, nurse practitioner, physician assistant working with a generalist)	(1)	(2)	86. GOC10A1
GOC10B	b. Specialist visit (diabetologist, endocrinologist, or nurse, nurse practitioner, physician assistant working with a diabetologist or endocrinologist)	(1)	(2)	88. GOC10B1
GOC10C	c. Nurse educator or certified diabetes educator for diabetes education only	(1)	(2)	90. GOC10C1
GOC10D	d. Dietitian	(1)	(2)	92. GOC10D1
GOC10E	e. Psychiatrist	(1)	(2)	94. GOC10E1
GOC10F	f. Psychologist	(1)	(2)	96. GOC10F1
GOC10G	g. Social worker	(1)	(2)	98. GOC10G1
GOC10H	h. Ophthalmologist (eye specialist, M.D.)	(1)	(2)	100. GOC10H1
GOC10I	i. Optometrist (eye specialist, not an M.D.)	(1)	(2)	102. GOC10I1
GOC10J	j. Cardiologist (heart specialist)	(1)	(2)	104. GOC10J1
GOC10K	k. Podiatrist (foot specialist)	(1)	(2)	106. GOC10K1
GOC10L	l. Nephrologist (kidney specialist)	(1)	(2)	108. GOC10L1
GOC10M	m. Gastroenterologist (digestive disease specialist- stomach, liver, gall bladder, bowel)	(1)	(2)	110. GOC10M1
GOC10N	n. Neurologist (nerve specialist)	(1)	(2)	112. GOC10N1
GOC10O	o. Oncologist (cancer specialist)	(1)	(2)	114. GOC10O1
GOC10P	p. Surgeon	(1)	(2)	116. GOC10P1
GOC10Q	q. Gynecologist or Obstetrician	(1)	(2)	118. GOC10Q1
GOC10R	r. Urologist (specialist for bladder problems, impotence)	(1)	(2)	120. GOC10R1
GOC10S	s. Dermatologist (skin specialist)	(1)	(2)	122. GOC10S1
GOC10T	t. Orthopedist (bone specialist)	(1)	(2)	124. GOC10T1
GOC10U	u. Physical Therapist	(1)	(2)	126. GOC10U1
GOC10V	v. Chiropractor	(1)	(2)	128. GOC10V1
GOC10W	w. Dentist	(1)	(2)	130. GOC10W1
GOC10X	x. Oral surgeon	(1)	(2)	132. GOC10X1
GOC10Y	y. Other health care provider(s), specify:	(1)	(2)	134. GOC10Y1
GOC10 OTH1 $40	GOC10YA1	(1)	(2)	136. GOC10YA1
GOC10 OTH2 $40	GOC10YB1	(1)	(2)	138. GOC10YB1

D. HOSPITALIZATIONS AND OTHER HEALTH CARE SERVICES USED

		YES	NO
GOD1 1.	During the past 12 months, were you admitted overnight to a hospital? This does not include emergency room visits or same day procedures. **If "no", go to D.2**	(1)	(2)
10. GOD1A a.	If "yes" to item #1, how many **times** in the past 12 months were you admitted overnight to a hospital for any reason?	___ ___	
11. GOD1B b.	If "yes" to item #1, how many total **nights** in the past 12 months did you stay in the hospital?	___ ___	

c. Please list the date(s) and name(s) of all the hospitals in which you have stayed overnight or longer during the past 12 months. (Make a separate entry for each time you were admitted. Attach a separate sheet if needed.)

Date of Admission (mo / day / yr)	Number of Nights	Hospital Name	City, State	
12. GOD1CA1 ___/___/ 96	143. GOD1CA2	144. GOD1CA3	145. GOD1CA4	146. GOD1CA
17. GOD1CB1 ___/___/ 96	148. GOD1CB2	149. GOD1CB3	150. GOD1CB4	151. GOD1CB
52. GOD1CC1 ___/___/ 96	153. GOD1CC2	154. GOD1CC3	155. GOD1CC4	156. GOD1C
57. GOD1CD1 ___/___/ 96	158 GOD1CD2	159. GOD1CD3	160. GOD1CD4	161. GOD1C
GOD1CE1 ___/___/ 96	163. GOD1CE2	164. GOD1CE3	165. GOD1CE4	166. GOD1C
GOD1CF1 ___/___/ 96	168. GOD1CF2	169. GOD1CF3	170. GOD1CF4	171. GOD1CF

		YES	NO
2. GOD2 2.	During the past 12 months, were you seen in a hospital Emergency Room for any reason? (Do not include Urgent Care Center or Walk-In clinic visits.) **If "no" go to D.3.**	(1)	(2)
3. GOD2A a.	If "yes" to item #2, how many **times** in the past 12 months were you seen in a hospital Emergency Room?	___ ___	
14. GOD2B b.	How many of these times were related to your diabetes?	___ ___	
15. GOD3 3.	During the past 12 months, were you a patient in a nursing home or convalescent facility? **If "no" go to D.4.**	(1)	(2)
16. GOD3A a.	If "yes" to Item #3, how many total nights in the past 12 months did you spend in a nursing home or convalescent facility?	___ ___ ___	

b. Please list the date(s) and name(s) of the nursing home(s) or convalescent facility(s) in which you have stayed during the past 12 months. (Make a separate entry for each time you were admitted. Attach a separate sheet if needed.)

Date of Admission (mo / day / yr)	Number of Nights	Institution	City, State	
17. GOD3BA1 ___/___/___	178. GOD3BA2	179. GOD3BA3	180. GOD3BA4	181. GOD3B
GOD3BB1 ___/___/___	183. GOD3BB2	184. GOD3BB3	185. GOD3BB4	186. GOD3B
37. GOD3BC1 ___/___/___	188. GOD3BC2	189. GOD3BC3	190. GOD3BC4	191. GOD3BC

4. During the past 12 months, have you had any of the following laboratory tests, x-rays, procedures, etc.?
   - DO NOT include any tests or procedures that may have been done while you were hospitalized.
   - DO NOT include evaluations performed as part of your EDIC visit.
   - CHECK ALL THAT APPLY.

	Test, X-ray, Procedure	YES	NO	# Times
a.	Glycosylated hemoglobin or HbA$_1$C	(1)	(2)	
b.	Fructosamine	(1)	(2)	
c.	Blood glucose (by lab or clinic)	(1)	(2)	
d.	Fasting lipid test (cholesterol)	(1)	(2)	
e.	Other blood tests	(1)	(2)	
f.	Electrocardiogram (EKG)	(1)	(2)	
g.	Stress test	(1)	(2)	
h.	Dilated eye exam	(1)	(2)	
i.	Eye photographs	(1)	(2)	
j.	Fluorescein angiogram (eye photos taken after injection of dye)	(1)	(2)	
k.	Laser treatment for eyes for diabetic retinopathy / macular edema	(1)	(2)	
l.	Timed urine collection	(1)	(2)	
m.	Other urine tests	(1)	(2)	
n.	Kidney dialysis	(1)	(2)	
o.	Gastric emptying studies	(1)	(2)	
p.	Pap Smear test	(1)	(2)	
q.	Flu shot	(1)	(2)	

5. During the past 12 months, have you had any other laboratory tests or evaluations? (1) (2)

   If "yes", specify: ______

6. During the past 12 months, have you received any other medical treatments? (1) (2)

   If "yes", specify: ______

7. How many days of work, school and/or usual activities have you missed in the past 12 months related to any illness? (Please include any days spent in the hospital.) ___ ___ ___

7a. How many of these days missed were related to your diabetes? ___ ___ ___

E. PARTICIPATION IN OTHER RESEARCH PROJECTS

Code	Item	YES	NO
GOE1	1. During the past 12 months, have you been asked to participate in any other health related research projects? **If "no", go to Section F.**	(1)	(2)
GOE2	2. If "yes" to item #1, did you actually participate in the project? **If "no", go to Section F.**	(1)	(2)
	3. If "yes" to item #2, did the research project involve: (CHECK ALL THAT APPLY.)	YES	NO
GOE3A	a. Specific drugs	(1)	(2)
GOE3B	b. Test procedures	(1)	(2)
GOE3C	c. Insulin regimen changes	(1)	(2)
GOE3D	d. Diet changes	(1)	(2)
GOE3E	e. Exercise modifications and/or recommendations	(1)	(2)
GOE3F	f. Questionnaires	(1)	(2)
GOE3G	g. Interviews	(1)	(2)
GOE3H	h. Other, specify: GOE3H1 ________	(1)	(2)

F. ACCESS TO HEALTH CARE SERVICES

Code	Item	YES	NO
GOF1	1. In the past 12 months, did you have **any health problem(s) or condition(s)** that you would have liked to have seen a doctor or other health care provider about, but you did not? **If "no" go to Item #3.**	(1)	(2)

2. If "yes" to item #1, please indicate below the reason(s) that explain why you did not see a doctor or other health care provider for this problem or condition. (CHECK ALL THAT APPLY.)

Code	Item	
GOF2A	a. Did not think that the condition was serious	(1)
GOF2B	b. Health care services for the problem or condition were not covered by health insurance	(2)
GOF2C	c. Thought the medical care would cost too much	(3)
GOF2D	d. Did not have money to cover the cost	(4)
GOF2E	e. Did not have time to see a health care provider	(5)
GOF2F	f. Could not get an appointment; office hours were inconvenient	(6)
GOF2G	g. Did not have a way to get to the office or clinic	(7)
GOF2H	h. Distance to clinic or doctor's office was too great	(8)
GOF2I	i. Did not have anyone to care for the children	(9)
GOF2J	j. Felt the health care provider could not help the condition	(10)
GOF2K	k. Did not feel the health care provider cared about my health	(11)
GOF2L	l. Was afraid of finding out what was wrong	(12)
GOF2M	m. Felt the problem could be remedied at home	(13)
GOF2N	n. Had a lapse in insurance	(14)
GOF2O	o. Other, specify: GOF2O1 ________	(15)

GOF3 3. In the past 12 months, do you feel that you **delayed** seeing a doctor or other health care provider longer than you should have? **If "no", go to Section G.**

	YES	NO
	(1)	(2)

4. If "yes" to item #3, please indicate below the reason(s) that explain why you delayed seeing a doctor or other health care provider for this problem or condition. (CHECK ALL THAT APPLY.)

Code	Item	Reason	
GOF4A	a.	Did not think that the condition was serious	(1)
GOF4B	b.	Health care services for the problem or condition were not covered by health insurance	(2)
GOF4C	c.	Thought the medical care would cost too much	(3)
GOF4D	d.	Did not have money to cover the cost	(4)
GOF4E	e.	Did not have time to see a health care provider	(5)
GOF4F	f.	Could not get an appointment; office hours were inconvenient	(6)
GOF4G	g.	Did not have a way to get to the office or clinic	(7)
GOF4H	h.	Distance to clinic or doctor's office was too great	(8)
GOF4I	i.	Did not have anyone to care for the children	(9)
GOF4J	j.	Felt the health care provider could not help the condition	(10)
GOF4K	k.	Did not feel the health care provider cared about my health	(11)
GOF4L	l.	Was afraid of finding out what was wrong	(12)
OF4M	m.	Felt the problem could be remedied at home	(13)
OF4N	n.	Had a lapse in insurance	(14)
GOF4O	o.	Other, specify: GOF401	(15)

G06 **G. MEDICAL RELEASE FORM**

The attached Medical Release Form is requested to obtain additional information relating to any hospitalizations and/or admissions to long term care facilities. This information will be used by the EDIC study and the EDIC staff to gain a better understanding of the health problems experienced and services used by EDIC participants. **Please read the Medical Release Form and complete the Patient Identification portion only, located at the bottom of the form.**

Thank you for completing the questionnaire. The data will be used to evaluate the type of health care you and other EDIC participants are receiving.

WEEKNO ______

AUTHORIZATION TO RELEASE PATIENT RECORDS

I hereby authorize the release of my medical and billing records and/or the complete record of my hospitalizations to the EDIC study. This authorization includes obtaining photocopies and abstracting information from the face sheet, ambulance / EMT report, emergency department report, history and physician examination, progress notes, nursing notes, and operative, pathology, histology, and laboratory reports. It also includes obtaining information on the charges incurred during the hospital stay. I understand that the information obtained will be used only for the purposes of this medical research project and will be held in strict confidence.

I understand that furnishing all of the requested information on this form is voluntary. The principal purpose of requesting the information on this form is to legally comply with the request to obtain or send medical records. I request that this authorization remain in effect unless revoked by the undersigned.

I authorize ____

____

____

to disclose to ____

____

____

a complete record of my medical findings. The information is required for verification of medical conditions and treatment dates. Please send copies of the following:

____ Face Sheet(s) with Discharge / ICD Codes
____ Emergency Department Report(s)
____ Discharge Summary(s)
____ Admission Summary(s) and H & P
____ All Pathology Reports
____ All Laboratory Results
____ All Surgical Reports
____ All Radiology, Cardiology, & Ultrasound Reports
____ Other: ____

____

____

PATIENT IDENTIFICATION

The following information is needed to assure accurate patient identification.

______________________ PATIENT (Print Name)

______________________ PATIENT SIGNATURE ______ DATE

______________________ DATE OF BIRTH

You may retain a copy of this authorization - Initial here if you desire a copy