EDIC EPIDEMIOLOGY OF DIABETES INTERVENTION AND COMPLICATIONS

1. Form

March 24, 1994
EDIC Form 091.2.IA

EPIDEMIOLOGY OF DIABETES INTERVENTION AND COMPLICATIONS

Verification of Cerebrovascular Event

This form should be completed in conjunction with the Annual Medical History and Physical Exam (EDIC Form 002) only if there is a positive response to Question J.2. One form for each event should be completed. Send the completed form to the Data Coordinating Center in your monthly mailing and retain a copy in the patient's file for your records.

A. IDENTIFYING INFORMATION

2.CLINIC 1. Clinic Number __ __

3.PATIENT 2. Patient ID Number __ __ __ __ __

4.INITIALS 3. Patient's Initials __ __ __

5.FORMDATE 4. Date form completed
Month Day Year

B. RECOGNITION OF EVENT

6.IABIADAT 1a) Specify date of occurrence or recognition of the event:
Month Day Year

OR

7.IABIB b) If date uncertain, check here: (1)

8.IAB2BDAT 2. Specify date EDIC clinic learned of the event:
Month Day Year

9.IAB3 3. How did clinic learn of the event?

Annual Medical History and Physical Exam (1)
Quarterly Telephone Interview (2)
Patient/Family notified clinic (3)
Third party notified clinic (4)
Clinic recognized event and informed patient (5)

C. CEREBROVASCULAR ACCIDENT:

1. Were one or more of the following symptoms and/or signs present? (check all that apply)

	No	Yes	Unknown
a) Carotid Arterial System			
i) Weakness or numbness in contralateral limbs? 10.IAC1A1	(1)	(2)	(3)
ii) Contralateral homonymous hemianopsia 11.IAC1A2	(1)	(2)	(3)
iii) Dysphasia 12.IAC1A3	(1)	(2)	(3)
iv) Agnosia 13.IAC1A4	(1)	(2)	(3)
b) Vertebral-Basilar Artery System			
i) Weakness of single or multiple limbs 14.IAC1B1	(1)	(2)	(3)
ii) Numbness of the face (especially the mouth) 15.IAC1B2	(1)	(2)	(3)
iii) Diplopia 16.IAC1B3	(1)	(2)	(3)
iv) Dysphagia 17.IAC1B4	(1)	(2)	(3)

b) Vertebral-Basilar Artery System (continued)

			No	Yes	Unknown
18. IAC1B5	v)	Dysarthria	(1)	(2)	(3)
19. IAC1B6	vi)	Hemonymous hemianopsia	(1)	(2)	(3)
20. IAC1B7	vii)	Ataxia	(1)	(2)	(3)
21. IAC1B8	viii)	Nystagmus	(1)	(2)	(3)
22. IAC1B9	ix)	Altered consciousness	(1)	(2)	(3)
23. IAC1B10	x)	Vertigo	(1)	(2)	(3)
24. IAC1B11	xi)	Nausea	(1)	(2)	(3)

	No	Yes	Unknown
2. a) Did the symptoms and/or signs persist for at least 10 minutes but for less than 24 hours? 25. IAC2A	(1)	(2)	(3)
b) Were the symptoms and/or signs persistent over 24 hours? 26. IAC2B	(1)	(2)	(3)
3. Was there a <u>persistent</u> abnormality of central nervous system function manifested either by:			
a) Neurological examination? 27. IAC3A	(1)	(2)	(3)
b) Disability that interferes with normal daily activities? 28. IAC3B	(1)	(2)	(3)
4. Was angiography or non-invasive testing performed for confirmation? 29 IAC4	(1)	(2)	(3)

Person completing form:

_____

Certification Number

__-__ 30 CERTIF

31. WEEKNO