1. FORM

EPIDEMIOLOGY OF DIABETES INTERVENTIONS 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

1. Clinic Number 2. CLINIC __ __
2. Patient ID Number 3. PATIENT __ __ __ __ __
3. Patient's Initials 4. INITIALS __ __ __
4. Date form completed 5. FORMDATE __ Month __ Day __ Year

B. RECOGNITION OF EVENT

1a) Specify date of occurrence or recognition of the event: 6. IAB1ADAT __ Month __ Day __ Year

OR

b) If date uncertain, check here: 7. IAB1B (1)

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

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

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

4. Was the patient treated within a health care facility for this event?

NEW

	No	Yes
a) Emergency room 10 IAB4A	(1)	(2)
b) Inpatient hospitalization 11 IAB4B	(1)	(2)
c) EDIC clinic 12 IAB4C	(1)	(2)
d) Other, specify ________ 13 IAB4D	(1)	(2)

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? 14. IAC1A1	(1)	(2)	(3)
ii) Contralateral homonymous hemianopsia 15. IAC1A2	(1)	(2)	(3)
iii) Dysphasia 16. IAC1A3	(1)	(2)	(3)
iv) Agnosia 17 IAC1A4	(1)	(2)	(3)
b) Vertebral-Basilar Artery System			
i) Weakness of single or multiple limbs 18. IAC1B1	(1)	(2)	(3)
ii) Numbness of the face (especially the mouth)	(1)	(2)	(3)

* 19. IAC1B2

	No	Yes	Unknown
iii) Diplopia 20. IAC1B3	(1)	(2)	(3)
iv) Dysphagia 21. IAC1B4	(1)	(2)	(3)

b) Vertebral-Basilar Artery System (continued)

	No	Yes	Unknown
22. IAC1B5 v) Dysarthria	(1)	(2)	(3)
23. IAC1B6 vi) Hemonymous hemianopsia	(1)	(2)	(3)
24. IAC1B7 vii) Ataxia	(1)	(2)	(3)
25. IAC1B8 viii) Nystagmus	(1)	(2)	(3)
26 IAC1B9 ix) Altered consciousness	(1)	(2)	(3)
27 IAC1B10 x) Vertigo	(1)	(2)	(3)
28 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? 29. IAC2A	(1)	(2)	(3)
b) Were the symptoms and/or signs persistent over 24 hours? 30. IAC2B	(1)	(2)	(3)

3. Was there a persistent abnormality of central nervous system function manifested either by: 31. IAC3A

	No	Yes	Unknown
a) Neurological examination?	(1)	(2)	(3)
b) Disability that interferes with normal daily activities? 32. IAC3B	(1)	(2)	(3)
4. Was angiography or non-invasive testing performed for confirmation? 33. IAC4	(1)	(2)	(3)

5. Were any diagnostic tests performed on this patient? No (1) Yes (2) 34. IAC5

If yes, what tests were performed and what were the results?

NEW

		Result: Positive	Negative	Equivocal
35. IAC5TES1 Test 1	TEST1	(1)	(2)	(3) 36. IAC5RES1
37. IAC5TES2 Test 2	TEST2	(1)	(2)	(3) 38. IAC5RES2
39. IAC5TES3 Test 3	TEST3	(1)	(2)	(3) 40. IAC5RES3
41. IAC5TES4 Test 4	TEST4	(1)	(2)	(3) 42. IAC5RES4
43. IAC5TES5 Test 5	TEST5	(1)	(2)	(3) 44. IAC5RES5

Person completing form: ________ Certification Number __-__ 45. CERTIF

46. WEEKNO