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. Patient ID Number __ __ __ __ __
3. Patient's Initials __ __ __
4. Date form completed __ __ __ __ __ __
   Month Day Year
5. EDIC follow-up year (complete either a or b)
   a) The event was reported at the annual visit. What is the EDIC follow-up year? __ __
   b) The event was reported between two annual visits. What is the LAST EDIC follow-up year? __ __

B. RECOGNITION OF EVENT (since last annual visit)

0. Confirmation of cerebrovascular events

	No	Yes
a) Cerebrovascular accident (CVA)	(1)	(2)
b) Transient ischemic attack (TIA)	(1)	(2)

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

   OR

   b) If date uncertain, check here: (1)

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

3. How did clinic learn of the event?

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?

	No	Yes
a) Emergency room	(1)	(2)
b) Inpatient hospitalization	(1)	(2)
c) EDIC clinic	(1)	(2)
d) Other, specify _____	(1)	(2)

C. CEREBROVASCULAR ACCIDENT:

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

   a) Carotid Arterial System

	No	Yes	Unknown
i) Weakness or numbness in contralateral limbs?	(1)	(2)	(3)
ii) Contralateral homonymous hemianopsia	(1)	(2)	(3)
iii) Dysphasia	(1)	(2)	(3)
iv) Agnosia	(1)	(2)	(3)

   b) Vertebral-Basilar Artery System

	No	Yes	Unknown
i) Weakness of single or multiple limbs	(1)	(2)	(3)
ii) Numbness of the face (especially the mouth)	(1)	(2)	(3)
iii) Diplopia	(1)	(2)	(3)
iv) Dysphagia	(1)	(2)	(3)

c) Vertebral-Basilar Artery System

	No	Yes	Unknown
v) Dysarthria	(1)	(2)	(3)
vi) Hemonymous hemianopsia	(1)	(2)	(3)
vii) Ataxia	(1)	(2)	(3)
viii) Nystagmus	(1)	(2)	(3)
ix) Altered consciousness	(1)	(2)	(3)
x) Vertigo	(1)	(2)	(3)
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?	(1)	(2)	(3)
b) Were the symptoms and/or signs persistent over 24 hours?	(1)	(2)	(3)
3. Was there a <u>persistent</u> abnormality of central nervous system function manifested either by:			
a) Neurological examination?	(1)	(2)	(3)
b) Disability that interferes with normal daily activities?	(1)	(2)	(3)
4. Was angiography or non-invasive testing performed for confirmation?	(1)	(2)	(3)

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

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

	Result: Positive	Negative	Equivocal
Test 1 _____	(1)	(2)	(3)
Test 2 _____	(1)	(2)	(3)
Test 3 _____	(1)	(2)	(3)
Test 4 _____	(1)	(2)	(3)
Test 5 _____	(1)	(2)	(3)

Person completing form: _____ Certification Number __ __-__ __