EDIC EPIDEMIOLOGY OF DIABETES INTERVENTION AND COMPLICATIONS

1. FORM

EPIDEMIOLOGY OF DIABETES INTERVENTION AND COMPLICATIONS

Verification of Psychiatric Disease Requiring Treatment

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.4. 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. IDB1ADAT
   Month Day Year

   OR

b) If date uncertain, check here: 7. IDB1B (1)

2. Specify date EDIC clinic learned of the event: 8. IDB2DAT
   Month Day Year

3. How did clinic learn of the event? 9. IDB3

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

C. NATURE OF EVENT:

		No	Yes
1. Was the patient treated by:			
a) Psychiatric social worker	10. IDC1A	(1)	(2)
b) Psychologist	11. IDC1B	(1)	(2)
c) Psychiatrist	12. IDC1C	(1)	(2)
d) Other, specify: _____	13. IDC1D / 14. IDC1DOTH	(1)	(2)
2. Did the patient receive outpatient treatment?	15. IDC2	(1)	(2)
If yes, where was the treatment given?			
a) Emergency room	16. IDC2A	(1)	(2)
b) Office	17. IDC2B	(1)	(2)
c) While on medical/surgical inpatient service for a primary medical problem		(1)	(2) 18. IDC2C
d) Other, specify: _____	19. IDC2D / 20. IDC2DOTH	(1)	(2)
3. Did the patient receive inpatient treatment? (i.e. hospital admission to a psychiatric service for a primary psychiatric diagnosis)	21. IDC3	(1)	(2)

Patient ID _____

	No	Yes
4. Using the criteria in the Diagnostic & Statistical Manual of Mental Disorders III, was a diagnosis of psychiatric illness made?	22. IDC4A (1)	(2)

If yes, specify the diagnosis and treatment provided:

_____ 23. IDCDIAG-N

_____ ?

_____

Name of person completing this form:

_____

Certification No.

24. CERTIF

_ _ - _ _

25. WEEKNO