

EPIDEMIOLOGY OF DIABETES INTERVENTIONS 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 D.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

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-IDB1ADAT 1a) Specify date of occurrence or recognition of the event: \_\_\_\_\_  
 Month Day Year

OR

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

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

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

Annual Medical History and Physical Exam	( 1 )
Telephone Call (was specific)	( 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	<u>10-IDC1A</u> ( 1 )	( 2 )
b) Psychologist	<u>11-IDC1B</u> ( 1 )	( 2 )
c) Psychiatrist	<u>12-IDC1C</u> ( 1 )	( 2 )
d) Other, specify: <u>14-IDC1DOTH</u>	( 1 )	<u>13-IDC1D</u> ( 2 )
2. Did the patient receive outpatient treatment? <u>15-IDC2</u>	( 1 )	( 2 )
If yes, where was the treatment given?		
a) Emergency room	<u>16-IDC2A</u> ( 1 )	( 2 )
b) Office	<u>17-IDC2B</u> ( 1 )	( 2 )
c) While on medical/surgical inpatient service for a primary medical problem	<u>18-IDC2C</u> ( 1 )	( 2 )
d) Other, specify: <u>20-IDC2DOTH</u>	( 1 )	( 2 )
3. Did the patient receive inpatient treatment? <u>21-IDC3</u>	( 1 )	( 2 )
(i.e. hospital admission to a psychiatric service for a primary psychiatric diagnosis)		

No Yes

4. Using the criteria in the Diagnostic & Statistical Manual of Mental Disorders III, was a diagnosis of psychiatric illness made?

( 1 ) ( 2 ) 2.2 IDC4

If yes, specify the diagnosis and treatment provided:

23 IDC DIAGN  
\_\_\_\_\_  
\_\_\_\_\_

Name of person completing this form:

Certification No

24 CERTIF

25 WEEK NO