EPIDEMIOLOGY OF DIABETES INTERVENTIONS AND COMPLICATIONS

Verification of Major Accident

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.7. 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

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 & informed patient (5)

C. NATURE OF EVENT:

1. What type of major accident did the patient have?
   a) Motor Vehicle accident (1)
   b) Sports-related accident (2)
   c) On-the-job accident (3)
   d) Farming accident (4)
   e) Other, specify: ____________________ (5)

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2. Please give a BRIEF description of the accident.

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3. Patient Hospitalization
   Which of the following did the patient require:
   a) Medical attention but not hospitalization (1)
   b) Hospitalization (2)
   c) Overnight hospitalization (3)
   d) Other (specify): ____________________ (4)

4. Where was (is) the patient (being) treated?
(check all that apply)

a) Emergency room (1)

b) Hospital inpatient ward (1)

c) EDIC clinic (1)

d) Other, specify: ______________________ (1)

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5. Was any operation performed or treatment prescribed to treat the patient as a result of this accident?

No	Yes
(1)	(2)

If yes, specify intervention and result:

		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)

6. Specify the period of treatment required as a result of this accident:

a) Date of admission or start of treatment: __ __ __ __ __ __
Month Day Year

b) i. If treatment is still in progress check here: (1)

ii. Otherwise, enter date of discharge or conclusion of treatment: __ __ __ __ __ __
Month Day Year

7. Indicate which of the following occurred as a result of this accident:
(check all that apply)

a) Death (Complete Form 140) (1)

b) Injury to another person (1)

c) Property damage (1)

d) Traffic violation (1)

e) Other, specify: ______________________ (1)

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8. In the clinic's opinion, what role did hypoglycemia play in this accident?

   a) Not a factor (1)

   b) Possible cause (2)

   c) Probable cause (3)

   d) Definite cause (Complete Form 042) (4)

9. Please provide a brief description to support your answer to the above statement regarding the role of hypoglycemia in this accident.

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Name of person completing this form: ____________________________________

Certification No. __ __ - __ __