

## FORM 1: PARENTS AND SIBLINGS OF EDIC/DCCT PATIENT

	A. IDEN	NTIFYIN	IG INFORMATIO	NC								
	1. (	Clinic Nu	umber:									
	2. F	Patient I	D Number:									
	3. F	Patient's	Initials:									
	4. F	Form da	te:									
(FOLD HERE)				m	o day	yr						
If more than 6 siblings, use extra copies of Page 1. Code 7 <sup>th</sup> sibling as 67, etc. Complete ID information	If patie memb diabet	ers of th	opted, disregard ne immediate fai	d Page 1 of the mily of the DC	is form, but in CT/EDIC pati	dicate that the ent, listing the	patient is ado patient as a "d	pted, and use child" below. S	Supply inform	ation in "If [	Please provid Diabetic" colun	le information for nns only if patient is
on all pages).		: :	SAME	;		:			IF DI	ABETIC	•	
<u>NAME</u>	CODE	SEX	BIOLO- GICAL PARENTS? No(1)	DATE OF BIRTH Mo/Day/Yr	No (1)	CURRENT AGE OR AGE AT DEATH Years	DIABETIC? No(1) Yes(2)	AGE DIABETES DIAG- NOSED?	USE INSULIN? No (1) Yes (2)	RETINO- PATHY? No (1) Yes (2)	NEPHRO- PATHY? No (1) Yes (2)	RELIABLE PHONE # (W/AREA CODE) INDICATE DAY(D) OR EVENING (E)
	0000	<u> </u>	. 55 (=/	e, 2 a.y,	. 55 (=)		. 55(2)		. 00 (=)	. 55 (2)	. 00 (=)	
FATHER:	FA	М										
MOTHER:	MO	F										1 1
DCCT/EDIC PATIENT	PT					<u> </u>						: : : :
OLDESR SIBLING:	S1											
NEXT SIBLING	S2											
NEXT SIBLING	S3											
NEXT SIBLING	S4											
NEXT SIBLING	S5											
NEXT SIBLING	S6											
Does the DCCT/EDIC patient have	diabetic	offsprin	ıg? ( Y) ( N) If	yes, please o	omplete Form	n 2 showing the	e DCCT/EDIC	patient as fath	ner or mother			
	Name o	f person	n completing this	s form:			C	Certification No	o. (If complete	ed by e-mai	l, disregard)	
(FOLD HERE)												

## FORM 2: SPOUSE/OFFSPRING OF DCCT/EDIC PT (DO NOT USE IF NO AFFECTED CHILDREN)

	A. IDEN	NTIFYIN	IG INFORMATI	ON								
	1. Clinic Number:											
	2. I	Patient I	D Number:									
	2 1	D-4:4:-	. Initiala.									
	3. 1	Patients	s Initials:									
(FOLD HERE)	4. l	Form da	te:	me	o day	yr yr						
					•							
f more than 8 children, use extra opies of Page 1. Code 9 <sup>th</sup> child as 9, etc. Complete ID information on	provid	Please provide information for spouse and offspring of the DCCT/EDIC patient, listing the patient as a parent. If diabetic offspring was from previous marriage, provide information on biological parent (i.e., former spouse) and list other children of that marriage. For father or mother, as appropriate, indicate PT (patient) a WI (wife) or HU (husband) for other patient under CODE column. Supply information in "If Diabetic" columns only if family member is diabetic.								indicate PT (patient) and		
n all pages).	, IF							IF DI	DIABETIC			
			SAME BIOLO- GICAL PARENTS?	DATE OF	LIVING?	CURRENT AGE OR AGE AT	DIABETIC?	AGE DIABETES	USE INSULIN?	RETINO-	NEPHRO- PATHY?	RELIABLE PHONE # (W/AREA CODE)
<u>NAME</u>	CODE	SEV	No(1) Yes (2)	BIRTH Mo/Day/Yr	No (1)	DEATH	No(1) Yes(2)	DIAG- NOSED?	No (1) Yes (2)	No (1) Yes (2)	No (1) Yes (2)	INDICATE DAY(D) OR EVENING (E)
	CODE	SEA	165 (2)	IVIO/Day/11	165 (2)	Years	165(2)	NOSED!	165 (2)	168 (2)	165 (2)	OR EVENING (E)
ATHER:		М										
NOTHER:		F										
DLDEST CHILD:	C1					:		<u>.                                    </u>				
IEXT CHILD:	C2											
IEXT CHILD:	C3											
IEXT CHILD:	C4	<del>!                                    </del>										: :
IEXT CHILD:	<b>C</b> 5											
IEXT CHILD:	C6					<u>:</u> :		: : :				<u>.                                    </u>
IEXT CHILD:	C7	<u>:</u>										
IEXT CHILD:	C8	<u>:</u> :										
		<u>i                                      </u>		•	<u> </u>	i	<u>i</u>	<u>i</u>				i
	Name of person completing this form:  Certification No. (If completed by e-mail, disregard)											
(FOLD HERE)			, 5							,	. 5 7	
(I OLD HERE)												

## FORM 3: AFFECTED RELATIVES (FOR CLINIC USE ONLY – DO NOT SEND TO DCC)

A. IDENTIFYING INFORMATION

1. Clinic Number:							
2. Patient ID Number:							
3. Patient's Initials:							
4. Form date:							
mo day yr							
List names and addresses for any 1st degree relatives (parent, sibling or offspring) identified as diabetic on pages 1 or 2 of this form.							
NAME	ADDRESS						
	, isometer						