EDIC EPIDEMIOLOGY OF DIABETES INTERVENTIONS AND COMPLICATIONS

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Notification of Transfer to Inactive Status

This form must be completed whenever a Principal Investigator seeks to transfer a patient to inactive status. Transfer to inactive status implies a temporary or permanent moritorium on all efforts to involve the patient in any EDIC activities whatsoever The clinical center must notify the Data Coordinating Center at the time of any potential transfer to inactive status. The Follow-Up Committee will also review all transfers to inactive status. The original of this form is to be sent to the Data Coordinating Center in the monthly forms mailing. Retain a copy in the clinic files.

A. IDENTIFYING INFORMATION

. . . .

- 1. Clinic Number
- 2. Patient ID Number _____
- 3. Patient's Initials _____

. . . .

4. Date form completed ______

Month Day Year

B. INFORMATION ON TRANSFER TO INACTIVE STATUS

1.	Specify the reason for the notification of transfer to inactive status: (CHECK ALL THA	T APPLY)
	a) Catastrophic injury or illness leading to coma, dementia, or inability to participate in EDIC testing procedures	(1)
	b) Complete inaccessibility to monitoring of outcomes (for example, long term imprisonment)	(1)
	c) Patient has withdrawn consent for continued participation	(1)
	d) Patient has agreed to participate, but has cancelled repeatedly appointments	(1)
	e) Other (specify in Question 2)	(1)

c.

2.	Explain in detail reason for notification of transfer. (USE EXTRA SI	HEET IF :	NECESS	ARY)
3.	On what date would the proposed transfer to inactive status become effective? (IF IMMEDIATELY, ENTER TODAY'S DATE.)	 Month	Day	Year
	If uncertain, check here:	(1)		
PLA	NS FOR FUTURE CONTACT	No	Yes	Uncertain
1.	Do you anticipate that you will attempt to contact the patient in in the future?	(1)	(2)	(3)
	If NO, give reason(s):			
2.	Do you believe that the patient would be willing and able to return to an EDIC clinic for at least some outcome evaluations?			
	If YES or UNCERTAIN, specify plans for future patient followup:			

3. Who will be delivering the patient's diabetes care? (Specify names, addresses and phone numbers if known)

Signature of Principal Investigator: