T1DGC ASP Application for Additional Affected Sibling
(Affected Sibling Data from Proband or Guardian)

Family ID [ ] famid

Participant Identifier [ ][ ] pid
Clinic ID [ ][ ][ ][ ] e3center
Secondary ID [ ][ ][ ] psid

COMPLETE THIS FORM FOR EACH ADDITIONAL AFFECTED SIBLING AND SEND TO THE REGIONAL NETWORK CENTER FOR APPROVAL. UPON APPROVAL, ID LABELS FOR EACH PARTICIPANT WILL BE SENT.

1. Interview date [ ][ ] - [ ] - [ ][ ][ ][ ] d_elig
   Day Month Year

2. How was this form completed?
   MARK ALL THAT APPLY.
   - Phone interview [ ] 1 rc_phone
   - Face-to-face interview [ ] 1 rc_face
   - From existing records [ ] 1 rc_record

3. Who is completing this form?
   IF GUARDIAN COMPLETING FORM,
   READ ITALICIZED TEXT. ONLY ONE GUARDIAN
   IS INTERVIEWED.
   - Proband [ ] 1
   - Biological Father [ ] 2 sourcee
   - Biological Mother [ ] 3
   - Other Guardian [ ] 4

ONLY ONE INDIVIDUAL OF AN IDENTICAL TWIN PAIR MAY PARTICIPATE AS AN AFFECTED SIBLING.

4. Do you (*Does this child*) have another living full brother or sister who is not an identical twin who has been diagnosed with Type 1 diabetes? Full brothers and sisters are those that have the same biological mother and same biological father.
   - Yes [ ] 1
   - (STOP-INELIGIBLE) No [ ] 2 t1as
   - (STOP-INELIGIBLE) Don't know [ ] 9

Secondary ID: Additional Affected Siblings = AS3, AS4, AS5
Participant Identifier: AS3 = 07; AS4 = 08; AS5 = 09

Family ID

Participant Identifier ☐☐ Clinic ID ☐☐☐☐ Secondary ID ☐☐☐

5. At what age was this brother/sister *(child)* diagnosed with Type 1 diabetes?

   (If age of diagnosis 35 years or older, STOP-INELIGIBLE.) ☐☐ Years — onset

   (PENDING) *Don't know ☐ 9

6. Did this brother/sister *(child)* use insulin within 6 months of being diagnosed?

   (SKIP TO QUESTION 7.) Yes ☐ 1
   No ☐ 2 — insulin
   (PENDING) *Don't know ☐ 9

   a. Is there any other information to suggest that this brother/sister *(child)* has Type 1 (insulin dependent) diabetes?

      (APPLY TO ELIGIBILITY COMMITTEE. - PENDING) *Yes ☐ 1 — qtype1
      (STOP-INELIGIBLE) No ☐ 2

7. Once this brother/sister *(child)* started using insulin, did he/she ever stop using insulin for a period of 6 months or more for reasons other than a pancreas transplant?

   (STOP-INELIGIBLE) Yes ☐ 1
   No ☐ 2 — stoptx
   (Diagnosis < 6 months ago) Not applicable ☐ 3
   (PENDING) *Don't know ☐ 9

*Continue with form for all responses marked with an asterisk. Clinic staff to follow-up with appropriate individuals within 10 days in order to collect information not known at time of interview. Participants may need to contact physicians or other family members to obtain information. All "PENDING" responses refer to eligibility criteria and must be resolved before form is forwarded to the Regional Network Center.

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8. What is this brother's/sister's *(child's)* date of birth?

Day - Month - Year

dbey
d_birthe

Can not collect 8
*Don't know 9

9. What is this brother's/sister's *(child's)* current age?
CHILDREN LESS THAN 12 MONTHS CAN BE INCLUDED AFTER FIRST BIRTHDAY.

Years

agee

(PENDING) *Less than 12 months 00
*Don't know 9

10. Does this brother/sister *(child)* have a specific genetic disorder or disease that caused his/her diabetes? This would include maturity onset diabetes of youth (MODY).
IF YES OR DON'T KNOW, READ/SHOW PARTICIPANT CUE CARD.

(STOP-INELIGIBLE) Yes 1
No 2
(PENDING) *Don't know 9

modyoth

*Continue with form for all responses marked with an asterisk. Clinic staff to follow-up with appropriate individuals within 10 days in order to collect information not known at time of interview. Participants may need to contact physicians or other family members to obtain information. All "PENDING" responses refer to eligibility criteria and must be resolved before form is forwarded to the Regional Network Center.

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INTERVIEWER COMPLETED

11. Is this affected sibling eligible to participate in this study?
   - (SKIP TO QUESTION 13.) Yes ☐ 1
   - (SKIP TO QUESTION 13.) No ☐ 2
   - (ANY PENDING RESPONSES) Pending ☐ 3

   elig

12. Is an application to the Eligibility Committee required?
   - (PENDING) Yes ☐ 1
   - No ☐ 2

   apply

13. Interviewer ID [| | | |] code1i

14. ID of person editing this form [| | | |] code1e

COMPLETED ONLY IF APPLICATION TO ELIGIBILITY COMMITTEE REQUIRED.

15. Did the Eligibility Committee approve inclusion in the study?
   - Yes ☐ 1
   - No ☐ 2

   ok

16. Date Eligibility Committee decision received by clinic:

   [|] - [ ] - [| | |] d_dec
   Day - Month - Year