Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ 1st three letters of First Name: ___ ___ ___

Complete this form when a participant is diagnosed with diabetes.

Criteria for Diagnosis:

1) Symptoms of diabetes plus casual plasma* glucose concentration ≥ 200 mg/dL (11.1 mmol/L).
   - Casual is defined as any time of day without regard to time since last meal.
2) Fasting Plasma* Glucose (FPG) ≥ 126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 hours.
3) 2-hour Plasma* Glucose (PG) ≥ 200 mg/dL (11.1 mmol/L) during an OGTT. The test should be performed as described by WHO, using a glucose load containing the equivalent of 1.75g/kg body weight to a maximum of 75 g anhydrous glucose dissolved in water.
4) Unequivocal hyperglycemia with acute metabolic decompensation (e.g. ketoacidosis).

* Note: Serum is also acceptable.

A. REPORT INFORMATION

1. Date of Diagnosis: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)
2. Current visit or last scheduled visit preceding diagnosis of diabetes
   (Use **P1** for any phase 1 visit; Use **P2** for phase 2 visit; Use **00** for Baseline Phase 3 visit. Use **06**, **12**, **18**, etc. for phase 3 visits) ___ ___ months
3. Diagnosis made by: *(check one)* ☐ 1 TrialNet Laboratory ☐ 2 Other Facility
   a. If Other Facility, specify: _____ _____

B. HOSPITALIZATION INFORMATION

1. Was the participant hospitalized at the time of diagnosis? Y N
   If YES,
   a. Admission Date: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)
   b. Discharge Date: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)

C. SIGNS AND SYMPTOMS OF DIABETES

Did the participant experience:

	Yes / No		a. Month/Year of Onset
1. Polyuria	Y N	*If Yes,*	__ __ / __ __ __ __ (MM / YYYY)
2. Polydipsia	Y N	*If Yes,*	__ __ / __ __ __ __ (MM / YYYY)
3. Polyphagia	Y N	*If Yes,*	__ __ / __ __ __ __ (MM / YYYY)
4. Fatigue	Y N	*If Yes,*	__ __ / __ __ __ __ (MM / YYYY)

Did the participant experience:

5. Unexplained weight loss Y N
   If YES,
   a. Month and Year of onset __ __ / __ __ __ __ (MM / YYYY)
   b. Amount of weight lost ___ ___ . ___ lb OR ___ ___ . ___ kg

Initials of Person Completing this Form: _____ Date: _____

Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ 1st three letters of First Name: ___ ___ ___

C. SIGNS AND SYMPTOMS OF DIABETES (cont.)

6. Ketoacidosis Y N

If YES, report as many of the following as available:

	1. Result[2]	2. Units[3]	Reference Range (if available) 3. Low	4. High	5. Date
a. Plasma[1] Glucose	___.__		___.__	___.__	__/__/____ MM DD YYYY
b. pH (Serum)	_.__		_.__	_.__	__/__/____ MM DD YYYY
c. Serum Ketones (acetoacetate)	____		____	____	__/__/____ MM DD YYYY
d. Anion Gap	____		____	____	__/__/____ MM DD YYYY
e. Bicarbonate (Serum)	____		____	____	__/__/____ MM DD YYYY
f. Urine Ketones	____		____	____	__/__/____ MM DD YYYY

[1]Serum is also acceptable
[2]Results should be reported based on initial visit
[3]Units: 1=mg/dL 2=mmol/L 3=ug/mL 4=mEq/L 5=n/a

D. GLUCOSE LEVELS *(record information on recently measured glucose levels)*

	a. Glucose Result [1]	b. Units (*Check one*)	Reference Range (if available) c. Low	d. High	e. Glucose Date	f. Glucose Type	g. Measured By
1	___.__	☐1 mg/dl ☐2 mmol/L	___.__	___.__	__/__/____ MM DD YYYY	☐1 Random ☐2 Fasting ☐3 2-hr OGTT	☐1 TrialNet ☐2 Other Lab ☐3 Meter [2]
2	___.__	☐1 mg/dl ☐2 mmol/L	___.__	___.__	__/__/____ MM DD YYYY	☐1 Random ☐2 Fasting ☐3 2-hr OGTT	☐1 TrialNet ☐2 Other Lab ☐3 Meter [2]
3	___.__	☐1 mg/dl ☐2 mmol/L	___.__	___.__	__/__/____ MM DD YYYY	☐1 Random ☐2 Fasting ☐3 2-hr OGTT	☐1 TrialNet ☐2 Other Lab ☐3 Meter [2]

Initials of Person Completing this Form: _____ Date: _____

Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ 1st three letters of First Name: ___ ___ ___

4	___.___	☐ 1 mg/dl ☐ 2 mmol/L	___.___	___.___	__ __ / __ __ / __ __ __ __ MM DD YYYY	☐ 1 Random ☐ 2 Fasting ☐ 3 2-hr OGTT	☐ 1 TrialNet ☐ 2 Other Lab ☐ 3 Meter [2]

[1] Glucose levels must be based on plasma or serum
[2] Meter readings are NOT ACCEPTABLE diagnostic criteria

E. OTHER LABORATORY VALUES

Laboratory Values	Reference Range (*if available*)		
	a. Result	**b. Low**	**c. High**	**d. Date**
1. HbA1c *(only if obtained outside of TrialNet)*	__ __. __%	__ __ . __ %	__ __ . __ %	__ __ / __ __ / __ __ __ __ MM DD YYYY

Signature of physician reviewing this form: _____

Signature of Person Completing this Form _____

Date form completed: __ __ / __ __ / __ __ __ __
MM DD YYYY