

Site Number: _____ Screening ID: _____ - ____ First 3 Letters of First Name: _____

Complete this form at all 6-month post-treatment visits. A 2-hour mixed meal tolerance test must be completed at this visit.

A. VISIT INFORMATION

1. Date of visit: _____ / _____ / _____
MM DD YYYY

2. For which visit is this form being completed? (check one)

₃₁ Month 30 ₃₂ Month 36 ₃₃ Month 42 ₃₄ Month 48

3. Did visit occur at a site other than the primary study site? Y N

IF YES,

a. Indicate Site Number for reimbursement: _____

NOTE: Site Number must correspond to a TrialNet Clinical Center, Affiliate or Participating Physician

B. GENERAL PHYSICAL EXAMINATION

1. Collect the following physical assessments:

Note: Have the participant rest for 5 minutes before doing these assessments.

a. Temperature: _____ °C or _____ °F

b. Seated arm blood pressure: _____ mmHg / _____ mmHg
Systolic Diastolic

c. Seated heart rate: _____ Beats/minute

d. Seated respiratory rate: _____ Breaths/minute

e. Weight: _____ kg or _____ lbs

f. Height: _____ cm or _____ in

2. Record whether the following systems are normal or abnormal for the physical exam:

System	Normal?	System	Normal?
a. HEENT (Head, eyes, ears, neck, throat)	Y N	g. Abdomen	Y N
b. Neck	Y N	h. Musculoskeletal	Y N
c. Thyroid	Y N	i. Neurologic	Y N
d. Lungs	Y N	j. Genitourinary	Y N
e. Chest/Breasts	Y N	k. Skin/Nails	Y N
f. Heart/Circulatory	Y N	l. Lymph nodes	Y N

C. LABORATORY ASSESSMENTS COMPLETED

Were the following blood samples taken during this visit?

1. CBC with diff Y N 3. HbA1c Y N 5. T-cells (stored) Y N
2. Chemistries Y N 4. Immune testing Y N 6. RNA (stored) Y N

Initials (first, middle, last) of person completing this form: _____
F M L

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

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*