Diabetes TrialNet		ETES PILOT TRIAL CREENING FORM		Form NPP04 28Mar2007 (v1.2) Page 1 of 7
Site Number:	 Screening ID:		Participant Letters:	

Study Coordinator completes this form at the Infant Screening Visit to assess eligibility. In the case of multiple births, complete another NPP04 Infant Screening Form for each infant at this visit.

A. VISIT INFORMATION

- 1. Date of visit (*e.g.* 05/Sep/2006):
- 2. Was mother participating in this study during pregnancy (Entry A)?
- 3. Is the mother currently breastfeeding her baby?

If YES, complete forms related to nursing mothers (NPP09, NPP20M, and NPP22).

B. INFORMED CONSENT

- 1. Informed consent signed for new child?
 - a. If YES, date of written informed consent obtained:
- 2. Permission given to store mother's samples?
 - a. If YES, permission to store mother's genetic samples?
- 3. Permission given to store infant's samples?
 - a. If YES, permission to store infant's genetic samples?

C. INFANT DEMOGRAPHIC INFORMATION

1.	Date of birth:				/ / /							
2.	Time	of bi	rth (<i>e.g 13:36</i>):			: Hour	 Min					
3.	Sex (a	checi	k one):	\square_1	Male \square_2				Female			
4.	Ethnicity (check one): \Box_1				Hispanic or Latino				Not Hispanic or Latino			
5.	Race ((cheo	ck all that apply	v):								
		a.	American Inc	lian or A	Alaskan Native \Box_1 f				Other			
		b.	Asian					1)	Specify:			
	\Box_1 c. Black or African Am				erican			2)	Record the 3-digit	a)		
	\square_1 d. Native Hawaiian or				Other Pacific Islander				code for race/ethnicity	b)		
	\square_1 e. White								(International sites only):	c)		

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.).

Y

Y

Ν

Ν

//////	MONT	/	YEAR	<u> </u>
		Y	N	I
		Y	N	I

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Site	:	Screening ID	:	-	Letters:	Visit/	/		
D. 1	PREGNANC	Y AND INFA	NT ME	DICAL HIST	ORY				
1.	Did the moth	er experience a	any com	plications duri	ing this pregnancy?		Y	Ν	
	a. If YES,	specify:							
2.	Has the infan	t had any med	ical prob	olems <u>since bir</u>	<u>:th</u> ?		Y	Ν	
	a. If YES,	specify:							
E. 1	MOTHER O	MEGA-3 FAT	TY AC	ID SUPPLEN	MENTATION				
1.					applements or special anytime since delivered	al food products with ery?	Y	Ν	
	If NO, skip to	Section F.							
	a. If the mot fatty acid	Y	N						
	b. Record all	l available info	rmation	on DHA and o	mega-3 fatty acids ta	aken:			
	Brand	a) Dose	b) Unit	c) Frequency	d) Start Date	e) Stop Date	f) Currently taking?		
1)			□ ₁ μg □ ₂ mg	$\square_1 Day \\ \square_2 Week$	MONTH YEAR	MONTH YEAR	Y	Ν	
2)			□ 1 μg □ 2 mg	$\square_1 Day$ $\square_2 Week$	MONTH YEAR	MONTH YEAR	Y	Ν	
3)			□ 1 μg □ 2 mg	$\square_1 Day$ $\square_2 Week$	MONTH /YEAR	MONTH /YEAR	Y	Ν	
T I	MOTHED DI	ECENT EVEN	JTC						
F. 1		er have an imr		on within the <u>l</u>	<u>ast 14 days</u> ?		Y	Ν	
2.	Has the moth	er had any febr	ile infec	tious illness in	the last 14 days?		Y	N	
3.	Has the moth	?	Y	Ν					
4.	Did the moth		Y	Ν					
5.	Has the mother the last 30 day		ls (oral o	r inhaled) or o	ther immunosuppres	sive medications in	Y	Ν	
6.					ments or blood prod A) or in the last 30		Y	N	

new infant (Entry B)?

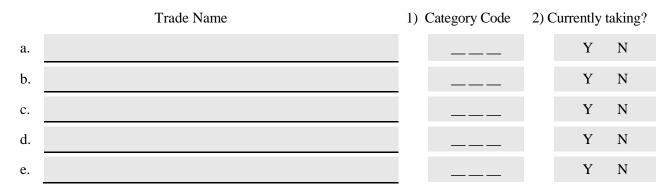
Type Dic Tri	alNet		NIP DIABETES P INFANT SCREEM			Form NPP04 28Mar2007 (v1.2) Page 3 of 7		
Site:		Screening ID:	·	Letters:	 Visit Date:	/	_/	

G. MOTHER MEDICATIONS

1. Has the mother taken any medications (prescription and non-prescription NOT including omega-3 fatty acids, DHA, vitamins, or dietary supplements) since giving birth? (*Refer to NWK02 Concomitant Medication Worksheet. Use NPP20M Pregnant Woman/Nursing Mother Vitamin and Dietary Supplement Form to record vitamins and dietary supplements.*)

Y N

If YES, fill in the following table. List all medications taken since giving birth. (*Use the Medication Category Codes below to complete Category Code*):



Med	Medication Category Codes:										
Use the Number Codes below to indicate the type of medication used:											
001	Antibiotic 006 NSAID										
002	Aspirin 007 Steroid Preparation										
003	Immunization	008	Thyroid Medication								
004	Immunosuppressive	999	Other								
005	Non-Insulin Diabetes Medication										

See Manual of Operations for example of medications that fall under each Medications Category code.

H. INFANT BIRTH HISTORY

- 1. Gestational age at birth:
 _____weeks
- 2. Birth measurements (if unavailable see below for correct notation):

a. Weight:	•kg	or	•_lb
b. Length:	•cm	or	•in

	abetes									
Site	:	Screening ID:		•	Letters:	Visit/	_/			
I. I	NFANT OM	EGA-3 FATT	Y ACID	SUPPLEME	NTATION					
1.					t vitamins, minera comega-3 fatty ac		Y	Ν		
	If NO, skip to	J.								
	a. Are the pa participati	Y	Ν							
	b. Record all	taken:								
	Brand	a) Dose	b) Unit	c) Frequency	d) Start Date	e) Stop Date	f) Curre taking?	ntly		
1)			$\Box_1 \mu g$ $\Box_2 mg$	$\square_1 Day \\ \square_2 Week$	MONTH YEAR	/ MONTH YEAR	Y	Ν		
2)			$\Box_1 \mu g$ $\Box_2 mg$	$\square_1 Day \\ \square_2 Week$	MONTH YEAR	//	Y	Ν		
3)			$\square_1 \mu g$ $\square_2 mg$	$\square_1 Day$ $\square_2 Week$	MONTH /YEAR	//	Y	Ν		
J. I	NFANT REO	CENT EVENT	S							
1.		t have an imm		within the las	t 14 days?		Y	Ν		
2.	Has the infant	t had any febril	e infectiou	us illness in th	e <u>last 14 days</u> ?		Y	N		
3.	Has the infant	t had any non-f	ebrile infe	ectious illness	in the <u>last 14 days</u>	?	Y	Ν		
4.	Did the infan	t take any antil	piotics wi	thin the <u>last 1</u>	<u>4 days</u> ?		Y	Ν		
5.	Has the infant the <u>last 30 day</u>		(oral or in	nhaled) or othe	er immunosuppres	sive medications in	Y	N		
6.	Has the infant days?	t received any i	mmunogl	obulin treatme	ents or blood produ	ucts in the <u>last 30</u>	Y	N		

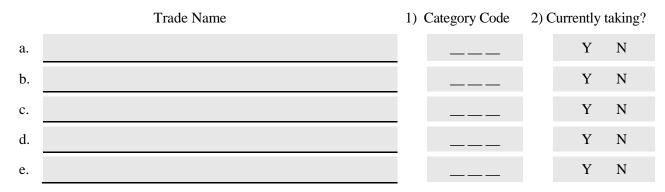
Type Dic Tri	alNet		NIP DIABETES P INFANT SCREEN			Form NPP04 28Mar2007 (v1.2) Page 5 of 7		
Site:		Screening ID:	·	Letters:	 Visit Date:	/	_/	

K. INFANT MEDICATIONS

1. Has the parent(s) or legal guardian given their infant any medications (prescription and nonprescription NOT including omega-3 fatty acids, DHA, vitamins, or dietary supplements) since birth? (*Refer to NWK02 Concomitant Medication Worksheet. Use NPP20 Infant Vitamin and Dietary Supplement Form to record vitamins and dietary supplements.*)

Y N

If YES, fill in the following table. List all medications given since birth. (*Use the Medication Category Codes to complete Category Code*):



Med	Medication Category Codes:										
Use the Number Codes below to indicate the type of medication used:											
001	Antibiotic 006 NSAID										
002	Aspirin 007 Steroid Preparation										
003	Immunization	008	Thyroid Medication								
004	Immunosuppressive	999	Other								
005	Non-Insulin Diabetes Medication										

See Manual of Operations for example of medications that fall under each Medications Category code.

L. INFANT PHYSICAL EXAM

1. Heart rate: beats per minute Respiratory rate: breaths per minute 2. 3. Weight: or kg lbs Length: 4. cm or in 5. Head circumference: cm or in 6. Temperature: or °C °F

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Site:	Screening	g ID:		Letters:	Visit Date:	/	_/		
L. INFA	ANT PHYSICAL E	XAM (C	ONTINUE	D)					
7. Are	the following system	n(s) norma	al by history	or exam?					
	System	Norn	nal?	1) If NO, describe	abnormali	ty:			
a.	HEENT	Y	Ν						
b.	Neck	Y	Ν						
c.	Thyroid	Y	Ν						
d.	Lungs	Y	Ν						
e.	Chest	Y	Ν						
f.	Heart	Y	Ν						
g.	Cardiovascular	Y	Ν						
h.	Abdomen	Y	Ν						
i.	Liver	Y	Ν						
j.	Spleen	Y	Ν						
k.	Musculoskeletal	Y	Ν						
1.	Neurologic	Y	Ν						
m	Urological/Renal	Y	Ν						
n.	Skin (including jaundice)	Y	Ν						
0.	Nails	Y	Ν						
p.	Lymph nodes	Y	Ν						
q.	Other:	Y	Ν						
r.	Describe any other	r pertinent	findings:						
s.	Physical exam con <i>print clearly</i>)	ducted by	r: (please	NAME					
t.	Date physical exar	n complet	ted:	DAY MONTH	YEAR				

D	iabetes rialNet					OT TRLA G FOR					Form NPP04 28Mar2007 (v1.2) Page 7 of 7		
Site	:	Screening	ID:				_ Le	tters:			Visit Date: —	_/	_/
M. 2	MOTHER SPI	ECIMEN				Cor		44.					
1.	Biochemical Autoantibodies	5	Colle Y	N	a	. Coi	mmen	115:					
N. 1	INFANT SPE	CIMEN C	OLLE	стю			~ ~ ~						
					N (0 (0	Aethoo <u>check a</u> Cord	<i>ıll that</i>]	<i>apply</i>): Heel	_				
1.	HLA typing		Colle Y	cted? N		Blood \Box_1		Stick \square_2	b. (Cor	nments:		
2.	Biochemical Autoantibodies	S	Y	Ν		□ 1							
	ner Cord Blood ecimens:	Collection	1		а	. Con	nment	s:					
3.	Vitamin D lev C-Reactive Pr (CRP)		Y	Ν									
4.	Fatty Acids (R Inflammatory	RBC) and	Y	Ν									
5.	Mediators If any cord blo	od samples	s were			_			_		a 1	1 00	
	collected, the r person(s) to the	elationship	of the				Famil	У		1	Study resea	arch staff	
	completed the Form and pack	Cord Bloo	d Colle				Friend	b			Other		
	the delivery ho <i>apply</i>):				C		Delivery staff		2	1	 Specify: 		

Initials (first, middle, last) of person completing this form:		F M L
Date form completed:	//////	YEAR