Participant Name: **Study ID:** **Date of contact:** / / (m m d d y y y y)

1. Date participant reported the diagnosis of diabetes or the prescribing or the start of diabetes-specific medication to the site (mm/dd/yyyy): / /

2. Type of initial contact with site: ◯ Telephone ◯ E-mail ◯ Study visit ◯ Other:

3. Setting of diabetes diagnosis or prescribing of diabetes specific medication.

(Where was the diagnosis of diabetes made or what was the setting where the medication was prescribed?)

- ◯ Outpatient primary care office (e.g. MD, NP, PA), **Name of practice or hospital:**
- ◯ Outpatient specialist office (e.g. MD, NP, PA, SA), **Name of practice or hospital:**
- ◯ Hospital – emergency room, **Name of hospital:**
- ◯ Hospital – inpatient, **Name of hospital:**
- ◯ Hospital – day surgery, **Name of hospital:**
- ◯ Health Screening – community health fair, **Name of site or sponsor (e.g., YMCA, VNA):**
- ◯ Health Screening – employee health, **Name of site:**
- ◯ Other (e.g. pharmacy), **Name:**

Provide details and/or additional information

4. Professional making the diagnosis of diabetes or prescribing the diabetes medication.

(Who told you that you had diabetes or who prescribed the medication)?

- ◯ Physician
- ◯ Nurse practitioner, physician assistant, surgical assistant
- ◯ Nurse
- ◯ Community health worker (lay person)
- ◯ Pharmacist
- ◯ Other. Indicate:

Name of person making the diagnosis:

Phone: ***Address:***

Provide details and/or additional information

Participant Name: **Study ID:** **Date of contact:** / / (m m d d y y y y)

5. Date of diabetes diagnosis (or start of diabetes specific medication). *When were you tested for diabetes? If the participant does not remember the date, ask additional questions to help him remember or to limit the date range, (e.g. if participant says the end of December, ask if it was before or after Christmas).*

Date of diabetes (mm/dd/yyyy): / /

Provide details and/or additional information

6. Reason for testing or reason for prescribing a diabetes-specific medication. *Ask open-ended questions, e.g. why were you tested for diabetes? If the participant does not know or the response is unclear, ask a more detailed or probing question, e.g. why did you go to the doctor? Were you having symptoms? What kind of symptoms?*

- ◯ Routine (e.g. well visit, pre-operative testing, health screening)
- ◯ Symptoms of diabetes. Indicate:
- ◯ Other illness or hospitalization (e.g. inpatient or emergency room
- ◯ Other. Indicate:

Provide details and/or additional information

7. Diabetes-specific medication prescribed. *Were you prescribed any medications for the diabetes? Have you started or stopped any new medicines or supplements since your last visit? Record name, dose, route, frequency, route, start date (end date), and reason for medication or supplement.*

Name	Dose	Route	Frequency	Start Date/End Date	Reason
		Inhaled		◯ Start ◯ End / /	
		Inhaled		◯ Start ◯ End / /	
		Inhaled		◯ Start ◯ End / /	
		Inhaled		◯ Start ◯ End / /	

Participant Name: **Study ID:** **Date of contact:** / / (m m d d y y y y)

8. Changes in lifestyle. *Are you doing anything differently since you were told you have diabetes? For example, changes to lifestyle (diet or physical activity. If yes, ask the participant to provide details regarding the changes he has made, when he made them.*

Follow-up appointment scheduled: ◯ **Yes** ◯ **No**

If Yes, date of appointment (mm/dd/yyyy): / /

Remind participant to bring all medications and supplements to visit

If no, reason:

Confirmatory glycemia testing (Fasting Plasma Glucose and Hemoglobin A1c) is required

if participant <u>has not</u> started diabetes specific medication

If confirmatory testing is required, remind participant to:

- Not eat or drink anything but water for the 8 hours before the visit.
- Not participate in vigorous physical activity for 24 hours before the visit.
- Not drink alcohol for 24 hours before the visit.
- Not smoke on the morning of the visit.
- Take all their morning medications with water before coming to the visit, <u>EXCEPT</u> the new diabetes medication(s)

Participant Name: _____ **Study ID:** _____ **Date of contact:** __/__/____ (m m d d y y y y)

Medical Record Requests:

Name of record holder	Date Request Sent	Sent via (mail, fax, e-mail)	Notes	Date received
	__/__/____	○ Mail ○ Fax ○ E-mail		__/__/____
	__/__/____	○ Mail ○ Fax ○ E-mail		__/__/____
	__/__/____	○ Mail ○ Fax ○ E-mail		__/__/____
	__/__/____	○ Mail ○ Fax ○ E-mail		__/__/____
	__/__/____	○ Mail ○ Fax ○ E-mail		__/__/____