



Patient ID Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Site	Sub-site	Sequential ID				

SEARCH 3 Extended Core Information Form

Complete the SEARCH 3 Extended Core Information Form at or after 6 months post-diagnosis as some data could be missed if done before the 6 months.

Note: For the DKA questions, the insulin use questions, and the antibody testing questions, the window of interest is from diagnosis to 6 months post diagnosis.

1. What is the participant's sex?

1 Female

2 Male

1a. Check information source for participant's sex.

1 Medical records

2 Provider/case source referral

3 Other (specify):

2. What is the participant's race/ethnicity? (check one)

1 White, Non-Hispanic White

2 Hispanic, Latino, Chicano, Mexican

3 Asian (e.g., Chinese, Japanese, Filipino, Vietnamese, Cambodian, Korean, Thai, Asian Indian)

4 African-American (Black)

5 Pacific Islander (e.g., Hawaiian, Samoan)

6 Native American

7 Other (specify):

2a. Check information source for race/ethnicity.

1 Medical records

2 Provider/case source referral

3 Other (specify):

3. What is the participant's date of diabetes diagnosis?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

3a. Check source of information for date of diagnosis.

1 Medical record

2 Provider/case source referral

3 Other (specify):

4. What is the participant's zip code of residence at diabetes diagnosis?

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4a. Check source of information for zip code of residence.

1 Medical record

2 Provider/case source referral

3 Other (specify): →

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5. What is the participant's county and state of residence at diabetes diagnosis?

County

State

5a. Check source of information for county and state.

1 Medical record

2 Provider/case source referral

3 Other (specify): →

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6. What is the participant's diabetes type...	...closest to diagnosis?	...the most recent one at 6 months?
	1 <input type="checkbox"/> Type 1 (IDDM)	1 <input type="checkbox"/> Type 1 (IDDM)
	2 <input type="checkbox"/> Type 1A	2 <input type="checkbox"/> Type 1A
	3 <input type="checkbox"/> Type 1B	3 <input type="checkbox"/> Type 1B
	4 <input type="checkbox"/> Type 2 (NIDDM)	4 <input type="checkbox"/> Type 2 (NIDDM)
	5 <input type="checkbox"/> MODY	5 <input type="checkbox"/> MODY
	6 <input type="checkbox"/> Secondary Diabetes	6 <input type="checkbox"/> Secondary Diabetes
7 <input type="checkbox"/> Other (specify):	7 <input type="checkbox"/> Other (specify):	
	<table border="1" style="width: 215px; height: 40px;"></table>	<table border="1" style="width: 245px; height: 40px;"></table>
6a. Check source of information.	1 <input type="checkbox"/> Medical record	1 <input type="checkbox"/> Medical record
	2 <input type="checkbox"/> Provider/case source referral	2 <input type="checkbox"/> Provider/case source referral
	3 <input type="checkbox"/> Other (specify):	3 <input type="checkbox"/> Other (specify):
	<table border="1" style="width: 225px; height: 85px;"></table>	<table border="1" style="width: 245px; height: 85px;"></table>

7. Were diabetes autoantibody (DAA) measures obtained at diagnosis or later?
 1 Yes 2 No

7a. If yes, check which measure below:

Test (antibody):	<input type="checkbox"/> GAD/GAA obtained	<input type="checkbox"/> IA2/ICA512 obtained	<input type="checkbox"/> ICA obtained	<input type="checkbox"/> IAA obtained
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8. Was height reported in the medical record? If yes, record height closest to the date of diagnosis.

1 Yes →

8a. Record height → .

Units: (*check one*) 1 cm 2 inches

8b. Record date when height was measured: → / /

Month Day Year

2 No

9. Was weight reported in the medical record? If yes, record weight closest to the date of diagnosis.

1 Yes →

9a. Record weight → .

Units: (*check one*) 1 kg 2 lb

9b. Record date when weight was measured: → / /

Month Day Year

2 No

10. Did the participant ever use insulin?

1 Yes → 10a. If yes, record the date started: / /

Month Day Year

2 No

3 No information

11. Was insulin ever discontinued?

1 Yes →

11a. If yes, record the date discontinued:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

11b. Did DKA occur while off of insulin?

1 Yes

2 No

11c. Was insulin restarted?

1 Yes → 11c(1) Record date restarted:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

2 No

2 No

3 No information

12. Does the participant have acanthosis nigricans?

1 Yes

2 No

3 No information

13. Was DKA noted in the medical record?

1 Yes If yes, complete the following information.

2 No

Date of DKA

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

Lowest bicarb . mEq/L

Lowest Blood pH 1 arterial

. 2 venous

3 capillary

4 unknown

Highest glucose mg/dl

Date of DKA

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

Lowest bicarb . mEq/L

Lowest Blood pH 1 arterial

. 2 venous

3 capillary

4 unknown

Highest glucose mg/dl

(Continue to next page to record additional DKA notations in the medical record)

<p>Date of DKA</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year </p>	<p>Lowest bicarb <input type="text"/> <input type="text"/> . <input type="text"/> mEq/L</p> <p>Lowest Blood pH 1 <input type="checkbox"/> arterial <input type="text"/> . <input type="text"/> <input type="text"/> 2 <input type="checkbox"/> venous 3 <input type="checkbox"/> capillary 4 <input type="checkbox"/> unknown</p> <p>Highest glucose <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg/dl</p>
<p>Date of DKA</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year </p>	<p>Lowest bicarb <input type="text"/> <input type="text"/> . <input type="text"/> mEq/L</p> <p>Lowest Blood pH 1 <input type="checkbox"/> arterial <input type="text"/> . <input type="text"/> <input type="text"/> 2 <input type="checkbox"/> venous 3 <input type="checkbox"/> capillary 4 <input type="checkbox"/> unknown</p> <p>Highest glucose <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg/dl</p>
<p>Date of DKA</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year </p>	<p>Lowest bicarb <input type="text"/> <input type="text"/> . <input type="text"/> mEq/L</p> <p>Lowest Blood pH 1 <input type="checkbox"/> arterial <input type="text"/> . <input type="text"/> <input type="text"/> 2 <input type="checkbox"/> venous 3 <input type="checkbox"/> capillary 4 <input type="checkbox"/> unknown</p> <p>Highest glucose <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg/dl</p>

FOR STUDY USE ONLY						
Date Completed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Completed by	<input type="text"/>
	Month	Day	Year			
Date Reviewed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Reviewer Code	<input type="text"/>
	Month	Day	Year			
Date Entered	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Data Entry Code	<input type="text"/>
	Month	Day	Year			