Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

(affix label here)

Patient ID Number | Site | Sub-site | Sequential ID

SEARCH Medical Record Validation of Self-Report

Record this information for the time period:

Month Day Year through Month Day Year

1. Date of encounter: Month Day Year

(Complete a separate form for each encounter)

2. Site of encounter (window is 6 months before visit):
   - 1 ❑ Outpatient clinic
   - 2 ❑ ED
   - 3 ❑ Inpatient
   - 4 ❑ Other
3. Provider type:
   - 1 ❑ Peds endocrinologist
   - 2 ❑ Pediatrician
   - 3 ❑ Family practice
   - 4 ❑ General practice
   - 5 ❑ Adult endocrinologist/diabetologist
   - 6 ❑ Internist
   - 7 ❑ NP/PA
   - 8 ❑ Eye doctor
   - 9 ❑ Diabetes educator
   - 10 ❑ Nutritionist
   - 11 ❑ Social work
   - 12 ❑ Unknown
   - 13 ❑ Other _____
4. Had there been any episodes of severe hypoglycemia?
   - 1 ❑ Yes
     - 1 ❑ Required other's assistance
     - 2 ❑ Administered glucagon
     - 3 ❑ Called 911
     - 4 ❑ Required ED visit
     - 5 ❑ Required hospitalization
   - 2 ❑ No
   - 3 ❑ Not indicated

5. Had there been any episodes of DKA?

1 ❑ Yes

1 ❑ Required ED visit

2 ❑ Required hospitalization

2 ❑ No

3 ❑ Not indicated

6. Had diabetes education occurred?

6a. Diabetes nurse education:

1 ❑ Yes

2 ❑ No

3 ❑ Not indicated

6b. Nutritionist:

1 ❑ Yes

2 ❑ No

3 ❑ Not indicated

6c. Social worker or psychologist:

1 ❑ Yes

2 ❑ No

3 ❑ Not indicated

FOR STUDY USE ONLY

Date Completed	Month	Day	Year	Completed by	
Date Reviewed	Month	Day	Year	Reviewer Code	
Date Entered	Month	Day	Year	Data Entry Code	