The Let's Prevent Diabetes Study:
A study about preventing diabetes

You will need to have the following things done throughout the morning

Fasting Blood Samples	☐	Blood Pressure	☐
Health Questionnaire	☐	Weight	☐
Hip/Waist Measurements	☐	2-Hour Blood Samples	☐
Height	☐	Pedometer Given	☐

Last Blood Samples Due At:

Personal Details

Name:

Home Address:

Postcode:

Gender: Male ☐ Female ☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

Contact Telephone Number:

GP Name:

Practice Number:

NHS Number:

Screening Venue:

Patient ID Number:

Patients must not have any of the following:

Diabetes	☐Yes	☐No
Housebound	☐Yes	☐No
Terminal Illness	☐Yes	☐No
Pregnant or lactating	☐Yes	☐No
Active Psychotic illness which means patient cannot give informed consent	☐Yes	☐No
Be taking part in any other clinical trials: If answered yes, please provide name of trial and any prescribed medication below	☐Yes	☐No

Blood Tests (venous whole blood) (fasting):

Yellow 2.7ml **(x1)** ☐ Yes ☐ No

Brown 4.7ml **(x1)** ☐ Yes ☐ No

Purple 2.5ml EDTA **(x1)** ☐ Yes ☐ No

Orange 9ml **(for freezer) (x1)** ☐ Yes ☐ No
(Do not take if not consented for stored samples)

Brown 9ml **(for freezer) (x1)** ☐ Yes ☐ No
(Do not take if not consented for stored samples)

Red 10ml EDTA **(x1)** ☐ Yes ☐ No

Urine sample collected **(x1)** ☐ Yes ☐ No

OGTT

410mls lucozade: ☐ Yes Time started: _____:_____

Sample Spinning

Blood samples spun ☐ Stored in box number/month: _____________

Hospital location: _____________

2 x Orange Numbers: ☐ ☐

2 x Brown Numbers: ☐ ☐

INSTRUCTIONS FOR FREEZER SAMPLES:

Orange samples should be spun and pipetted into 2 x 2ml vials within 30 minutes and then transferred to –20°C freezer. Yellow lids

Brown samples should be left to clot for 30 minutes and then spun and pipetted into 2 x 2ml vials and then transferred to –20°C freezer. Brown lids

Should be taken to the -80°C freezer at end of screening session.

If patient has not consented for genetics but has consented for stored samples please use a white label on top of the coloured lid

Blood Pressure

Blood pressure 1: ☐☐☐ / ☐☐☐ mmHg Heart Rate ☐☐☐ bpm

Systolic Diastolic

Blood pressure 2: ☐☐☐ / ☐☐☐ mmHg Heart Rate ☐☐☐ bpm

Systolic Diastolic

Blood pressure 3: ☐☐☐ / ☐☐☐ mmHg Heart Rate ☐☐☐ bpm

Systolic Diastolic

Average of last two: ☐☐☐ / ☐☐☐ mmHg

Systolic Diastolic

Patient ID Number:

Health Questionnaire

Please tick the box that best describes your ethnic origin:

WHITE:

White British ☐
White Irish ☐
Any other white background ☐

CHINESE:

Chinese ☐
Any other ☐

MIXED:

White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any other mixed race ☐

BLACK OR BLACK BRITISH:

Caribbean ☐
African ☐
Any other black background ☐

ASIAN OR ASIAN BRITISH:

Indian ☐
Pakistani ☐
Bangladeshi ☐
Any other Asian background ☐

Which language does the patient most often use? (***Please enter, in order, the language the patient most frequently uses)***

1st language

____

2nd language

____

3rd language

____

Smoking Status

Non-smoker	☐	Yes	☐	No
Ex-smoker	☐	Yes	☐	No
Current smoker	☐	Yes	☐	No

If **Ex-smoker**: Year stopped smoking ☐☐☐☐

How Many Used to smoke Per Day? ____________

If **Current smoker**

How many per day? ____________

Patient ID Number:

Medical History: Does the patient have a history of:

	Yes	No	Unknown	Date (yyyy)
MI	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Heart Valve Disease	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Heart Failure	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Atrial Fibrillation	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Angina	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Stroke	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Angioplasty/CABG	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Leg Angioplasty/bypass	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Peripheral Vascular Disease	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
High Blood Pressure	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
High Cholesterol	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
IGT/IFG	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Gestational Diabetes	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Polycystic Ovary Syndrome	Yes ☐	No ☐	Unknown ☐	☐☐☐☐
Thyroid Disorder	Yes ☐	No ☐	Unknown ☐	☐☐☐☐

Any other significant illness/event?

Does the patient currently take any medication?

Medication Type	Yes	No	Unknown	Name of Medication	Unknown
ACE-Inhibitor	☐	☐	☐		☐
Alpha-Blocker	☐	☐	☐		☐
ARB	☐	☐	☐		☐
Beta-Blockers	☐	☐	☐		☐
Calcium Channel Blockers	☐	☐	☐		☐
Diuretics/Thiazides	☐	☐	☐		☐
Aspirin	☐	☐	☐		☐
Lipid Lowering – Statin	☐	☐	☐		☐
Lipid Lowering – Fibrate	☐	☐	☐		☐
Steroids	☐	☐	☐		☐
Please indicate whether steroids are:		Oral	☐	Injected ☐	or Inhaled ☐
Thyroid/Anti-Thyroid	☐	☐	☐		☐
Multi-Vitamins	☐	☐	☐		☐
Vitamin C	☐	☐	☐		☐
Vitamin D	☐	☐	☐		☐

Any other medication?

Family History

Number of 1st degree relatives with diabetes (mother, father, brother or sister): ☐☐

Parent **or** sibling with diabetes: ☐ Yes ☐ No ☐ Unknown

Parent **and** sibling with diabetes ☐ Yes ☐ No ☐ Unknown

Patient ID Number:

Do the patient's 1st degree relatives have a history of:

				Age
Cardiovascular Disease	Yes ☐	No ☐	Unknown ☐	☐☐
Stroke	Yes ☐	No ☐	Unknown ☐	☐☐
High Blood Pressure	Yes ☐	No ☐	Unknown ☐	☐☐
High Cholesterol	Yes ☐	No ☐	Unknown ☐	☐☐

Blood Tests (120 mins)

Time taken: ☐☐:☐☐

Yellow 1 x 2.7 mls: ☐Yes ☐No

Red 10 ml EDTA ***(genetic)*** ☐Yes ☐No
(Do not take if patient has not consented for genetic analysis)

Anthropometric Measurements

Height: ☐:☐☐

Weight: ☐☐☐:☐☐

Hip Measurement: ☐☐☐

Hip Measurement: ☐☐☐

Additional Comments:

CRF Checked By (Name/Date) ________________ ☐☐/☐☐/☐☐☐☐