



## Royal College of Paediatrics and Child Health

### BPSU Follow-up Questionnaire: Surveillance of Non-type 1 Diabetes

Name of reporting health professional:

Name of clinician responsible for case:

Hospital name: **«HospitalClinic»**

If you are neither the named reporting health professional or the clinician responsible for the case please write your name below (*please print*):

\_\_\_\_\_

Month that case was reported: **«Month\_reported»**

Date of completing initial questionnaire: **«Date\_QA\_completed»**

Date of diagnosis of non-type 1 diabetes (from initial questionnaire):

Month/Year of Birth of patient: **«Month\_of\_birth»/«Year\_of\_birth»**      Gender of patient:  
**«Gender»**

Hospital Number of patient: **«Hospital\_number»**

*If you are a clinician:*

Are you / the clinician responsible named above still providing care for this patient?

**Yes**       **No**

*If you are a diabetic nurse specialist:*

Is the clinician responsible named above still providing care for this patient?

**Yes**       **No**

If No to either of the above please give the contact details for the clinician providing continuing care:

Name of clinician: \_\_\_\_\_

Hospital name: \_\_\_\_\_

Contact telephone number: \_\_\_\_\_

Contact e-mail: \_\_\_\_\_

**Section A: Diagnosis and treatment of non-type 1 diabetes**

1. What is your current diagnosis for this patient?

Type 2 diabetes

MODY

If YES has this been confirmed by genetic testing?  Yes  No

If YES (and if possible) then please enclose a copy of the *anonymised* lab report

Diabetes as part of a recognised syndrome  
Name of Syndrome: \_\_\_\_\_

Diabetes as part of a suspected or unrecognised syndrome

Diabetes secondary to another condition  
Name of Condition: \_\_\_\_\_

Type 1 diabetes

Other (please specify) \_\_\_\_\_

2. How was the diagnosis made? (*please tick if applicable and provide results*)

	Results (provide units)	Normal range
<input type="checkbox"/> Fasting insulin measurement		
<input type="checkbox"/> C-peptide (normal or raised?)		
<input type="checkbox"/> Ketonuria (positive or negative?)		

Have you conducted a GAD, islet cell, insulin antibody or HLA test?  Yes  No

If YES please specify antibody test (*please tick if applicable, provide test result and date*):

*N.B. If there is no new information to add since completing the first questionnaire then the section below can be omitted*

	Date of test	Result
<input type="checkbox"/> GAD-65	__/__/__	_____
<input type="checkbox"/> ICA	__/__/__	_____
<input type="checkbox"/> Anti-insulin antibodies	__/__/__	_____

3. Please give details of treatment that the patient *currently* on? (*please tick if applicable*)

Treatment	Date started	Dosage/drug name/type of other treatment
<input type="checkbox"/> Insulin		
<input type="checkbox"/> Oral Medication		
<input type="checkbox"/> Diet to control weight		
<input type="checkbox"/> Other Rx		

**Section B: Clinical results and symptoms**

4. Please give the patient’s most recent height and weight last measured together:

	Value	Date measured
Height (cm)		
Weight (kg)		

5. Please give the following clinical results for your patient and date of the last measurement:

	Result	Date measured
Blood pressure (mm Hg)		
Glycated Haemoglobin (Normal range for your laboratory: .....)		
Fasting / non-fasting lipid profile ( <i>please delete</i> )		
Total cholesterol (mmol/l)		
Triglyceride (mmol/l)		
LDL Cholesterol (mmol/l)		
HDL Cholesterol (mmol/l)		

6. During the last year has the patient developed any of the following?

- |                      |                              |                             |                                    |
|----------------------|------------------------------|-----------------------------|------------------------------------|
| Retinopathy          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Known |
| Nephropathy          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Known |
| Neuropathy           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Known |
| Acanthosis nigricans | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Known |
| PCOS                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Known |

7. Since completing the first questionnaire have any other relatives of this patient gone on to develop type 2 diabetes?

- Yes     No     Not Known

If YES please state relationship to patient: \_\_\_\_\_

*Thank you very much for taking the time to complete the questionnaire.*

**Please return in the SAE to:**  
**Kay Chong Wan, Research Administrator**  
**Royal College of Paediatrics and Child Health**  
**50 Hallam Street, London W1W 6DE**