CITY Visit Information Worksheet

Subject ID: _____ **Namecode:** _____

1a. Investigator taking responsibility for the visit: _____

1b. Coordinator taking responsibility for the visit: _____

2. Visit date:

_____ _____ / _____ _____ / _____ _____ _____ _____ ☐ Missed
(mm/dd/yyyy)

If *Missed*, reason (select only one):

- ☐ Bad weather
- ☐ Travel difficulty
- ☐ Financial issue
- ☐ Poor health
- ☐ Personal issue
- ☐ Work issue
- ☐ Subject on vacation
- ☐ Visits too lengthy
- ☐ Investigator away
- ☐ Clinic appointment not available
- ☐ Site forgot to schedule
- ☐ Difficulty contacting subject
- ☐ Poor outcome
- ☐ Good outcome
- ☐ Adverse event
- ☐ Unknown
- ☐ Other

2a. If *Other*, describe:

_____

_____

_____

OUT OF WINDOW

☐ **Visit was completed out of window**

1. Reason visit was completed out of window (select only one):

- ☐ Bad weather
- ☐ Travel difficulty
- ☐ Financial issue
- ☐ Poor health
- ☐ Personal issue
- ☐ Work issue
- ☐ Subject on vacation
- ☐ Visits too lengthy
- ☐ Investigator away
- ☐ Clinic appointment not available
- ☐ Site forgot to schedule
- ☐ Difficulty contacting subject
- ☐ Poor outcome
- ☐ Good outcome
- ☐ Adverse event
- ☐ Unknown
- ☐ Other

1a. If *Other*, describe:

_____

_____

_____

CITY Blinded Sensor Placement Worksheet

Subject ID: _____ **Namecode: _____**

BLINDED SENSOR PLACEMENT

1. Was a blinded sensor inserted at the visit?

O Yes O No

1a. If No, enter reason: _____

CITY Medical Conditions Form

Patient ID:

Namecode:

MEDICAL CONDITION

Estimate dates if necessary. If only the year is known, enter "January" as the month. When the day of the month is required but unknown, enter "1." Enter all medication treatment at the time of enrollment and started after enrollment on the Medications Form after entering the medical condition on this form.

Record medications in use during the study on the Medication Form.

1. Medical Condition: _____

2. Present prior to study enrollment?

☐ Yes ☐ No

2a. If *Yes* (present prior to enrollment), complete the following:

i. Approximate duration prior to enrollment:

☐ <=30 days
☐ >30 days to < 3 months
☐ 3 months to < 6 months
☐ 6 months to < 1 year
☐ 1 year to < 5 years
☐ 5 years to < 10 years
☐ >=10 years
☐ Unknown

ii. Treated with medication:

☐ Current ☐ Past ☐ Never

2b. If *No* (started or occurred after enrollment/randomization), complete the following:

i. Date of diagnosis: _____ _____ / _____ _____ / _____ _____ _____ _____ (mm/dd/yyyy)

☐ Approximate ☐ Unknown

ii. Treatment of the medical condition (select only one):

☐ None
☐ Medication
☐ Surgery
☐ Medication and Surgery
☐ Dietary Management
☐ Other

iii. If *Other*, describe:

_____
_____
_____

Patient ID:

Namecode:

Enter the recovery date for all conditions active at the time of enrollment or develop later that resolve during study.

STATUS OF CONDITION

1. Medical condition status:

- ☐ Ongoing (further improvement or worsening possible)
- ☐ Ongoing, medically stable (further change not expected)
- ☐ Complete Recovery
- ☐ Recovered with Sequelae

1a. If *Complete Recovery* or *Recovered with Sequelae*, complete the following:

Recovery date: _____ _____ / _____ _____ / _____ _____ _____ _____ ☐ Approximate
(mm/dd/yyyy)

CITY Medications Form

Patient ID:

Namecode:

MEDICATION

If treatment is for a medical condition or adverse event, a Medical Condition Form or Adverse Event Form must be completed before the medication is entered.

When you are updating a previously entered medication, if the medication dose or frequency has changed, enter the stop date for the current medication dose and then enter a new record for the new dose.

1. Medication Name: _____

2. Dose per administration (include unit):

Dose: _____ **Unit:** _____ or ☐ Unknown

3. Route (select only one):

☐ S.C. –subcutaneous	☐ Topical – skin	☐ Intra-articular injection
☐ I.V. - intravenous	☐ Vaginal	☐ Retrobulbar
☐ Gtt-drops	☐ Transurethral	☐ Transdermal
☐ I.D.-intradermal	☐ Oral Inhalation	☐ Subconjunctival
☐ I.M.-intramuscular	☐ Nasal	☐ Subtenons
☐ P.O.-by mouth	☐ Sublingual	☐ Intrauterine
☐ P.R.-by rectum	☐ Intravitreal	☐ Topical
☐ Topical – ocular	☐ Peribulbar	☐ Epidural

4. If treatment is for eye or ear, complete:

☐ Right ☐ Left ☐ Both

5. Frequency:

☐ Fixed Regimen
☐ As Needed
☐ One Time Treatment

5a. If *Fixed*, complete the following:

Frequency:

_____ per ☐ Day ☐ Week ☐ Month ☐ Year or ☐ Uncertain

Patient ID:

Namecode:

5b. If *As Needed*, approximate frequency (select only one):

☐ >1/d	☐ 2-6/wk	☐ 1/y
☐ 1/d	☐ 1/m	☐ 2-5/yr
☐ 1/wk	☐ 2-3/m	☐ 6-11/yr

6. Indication:

☐ Medical condition prior to enrollment
☐ New medical condition/adverse event
☐ Prevention

6a. If medical condition (either pre-existing or occurred during the study), indicate condition(s):

_____ **or**

☐ **Condition not required to be reported on pre-existing condition form**

6b. If "Treatment for Adverse Event," indicate adverse event(s):

_____

CITY Insulin Form

Patient ID:

Namecode:

INSULIN

Types of insulin will be recorded on this form. Doses will be recorded on visit forms.

If the pump is used routinely and injections are only used when there is a pump failure, only record the insulin used in the pump.

If both the pump and injections are used together (or sometimes one and sometimes the other), record the insulins separately (e.g., if the same insulin is sometimes used in a pump and sometimes in injections, enter separate records for each).

1. Insulin Name:

- ☐ Afrezza (insulin human)
- ☐ Apidra (Glulisine)
- ☐ Degludec
- ☐ Humalog (Lispro)
- ☐ Humalog 50/50
- ☐ Humalog 75/75
- ☐ Humulin 50/50
- ☐ Humulin 70/30
- ☐ Humulin N (NPH)
- ☐ Lantus (Glargine) 1 time per day
- ☐ Lantus (Glargine) 2 times per day
- ☐ Levemir (Detemir) 1 time per day
- ☐ Levemir (Detemir) 2 times per day
- ☐ Novolin 70/30
- ☐ Novolin N (NPH)
- ☐ Novolog (Aspart)
- ☐ Novolog 70/30
- ☐ Regular (R) (Humulin R or Novolin R)
- ☐ Toujeo (Glargine, U300)
- ☐ U500 Human R Regular
- ☐ Velosulin

2. Route:

☐ Pump ☐ Injection ☐ Inhaled

2a. If injection or inhaled, what is the usual frequency of injections per day?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ Unknown

3. Start Date of Insulin Type:

- ☐ In use at time of enrollment
- ☐ Started after enrollment
- ☐ Unknown

3a. If started after enrollment, start date:

_____ _____ / _____ _____ / _____ _____ _____ _____ ☐ Estimated ☐ Unknown
(mm/dd/yyyy)

4. Stop Date of Insulin Type (if permanently discontinued during the study):

_____ _____ / _____ _____ / _____ _____ _____ _____ ☐ Estimated ☐ Unknown
(mm/dd/yyyy)

CITY Diabetes Hypoglycemic Event Worksheet

Subject ID: _____ **Namecode:** _____

Please complete AE Form in addition to this form.

Reportable hypoglycemia *is defined as an event that required assistance of another person due to altered consciousness to actively administer carbohydrate, glucagon, or other resuscitative actions. This means that the participant was impaired cognitively to the point that the participant was unable to treat his or herself, was unable to verbalize his or her needs, was incoherent, disoriented, and/or combative, or experienced seizure or coma. By definition, events that meet these criteria are reported as Serious Adverse Events. Hypoglycemic events are also considered reportable If the above criteria are not met but emergency evaluation or treatment was obtained from a health care provider; these events are considered Adverse Events and not Serious Adverse Events unless one of the criteria for SAE is met.*

1. Date of event:

_____ _____ / _____ _____ / _____ _____ _____ _____

(mm/dd/yyyy)

☐ Approximate ☐ Unknown

1a. Indicate the approximate time of day of the event:

☐ 00:01 – 03:00
☐ 03:01 – 06:00
☐ 06:01 – 09:00
☐ 09:01 – 12:00
☐ 12:01 – 15:00
☐ 15:01 – 18:00
☐ 18:01 – 21:00
☐ 21:01 – 00:00
☐ Unknown

2. Was the glucose level checked on a home blood glucose meter?

☐ Yes ☐ No ☐ Unknown

2a. If *Yes*, what was the result? _____ ☐ mg/dL ☐ mmol/L ☐ Unknown

3. Was the participant wearing a CGM sensor at the time of the event (either alone or as part of an automated insulin delivery system)?

☐ Yes ☐ No ☐ Unknown

3a. If *Yes*, what was the glucose reading at the time the event was identified?

_____ ☐ mg/dL ☐ mmol/L ☐ Unknown

4. Was the participant wearing an automated insulin delivery system at the time of the event?

☐ Yes ☐ No ☐ Unknown

4a. If *Yes*, was the system in auto mode or manual mode?

☐ Auto Mode ☐ Manual Mode ☐ Unknown

5. Please select all of the following that apply for this event:

☐ Seizure
☐ Loss of consciousness
☐ Required assistance
☐ Ambulance called

☐ EMT assistance

☐ Evaluated or treated by health care provider (not EMT)

6. Was glucagon given?

☐ Yes ☐ No ☐ Unknown

7. Was the participant hospitalized or treated in the Emergency Room?

☐ Yes ☐ No ☐ Unknown

If *Yes*,

7a. Where was the participant treated?

☐ ICU only

☐ Floor only

☐ ICU and Floor

☐ Emergency Room only

☐ Unknown

7b. Duration *(leave blank if participant was treated in the emergency room only)*:

_____ days (use a midnight census and estimate if necessary ☐ Unknown

8. Cause of Event

8a. Is there any evidence that a study device (e.g., blood glucose meter, CGM, and/or pump) contributed to the event (either device malfunction or improper use by user)?

☐ Yes ☐ No

If *Yes*, please complete a Device Issue Form.

8b. Is there any indication of non-study device-related factors that contributed to the occurrence of the event?

☐ Yes ☐ No

If *Yes*, explanation of contribution of non-study device-related factors to the event:

_____

_____

_____

9. Outcome

☐ Fully recovered ☐ Other ☐ Unknown

If *Other*, describe:

_____

_____

_____

CITY Diabetes Severe Hyperglycemia or DKA Event Worksheet

Subject ID: _____ **Namecode:** _____

Please complete AE Form in addition to this form.

Severe Hyperglycemia or Diabetic Ketoacidosis *is defined as INSERT PROTOCOL SPECIFIC DEFINITION*

1. Date of event:

_____ _____ / _____ _____ / _____ _____ _____ _____

(mm/dd/yyyy)

☐ Approximate ☐ Unknown

2. Glucose level: _____ ☐ mg/dL ☐ mmol/L ☐ Unknown

3. Ketones: _____ ☐ Unknown

3a. Serum: _____ ☐ mg/dL ☐ mmol/L

3b. Urine: ☐ Negative ☐ Small ☐ Medium ☐ Large ☐ Extra Large

4. HCO3: _____ ☐ Unknown

5. pH: _____ ☐ Arterial blood ☐ Venous ☐ Unknown

6. BUN: _____ ☐ Unknown

7. Symptomatic cerebral edema: ☐ Yes ☐ No ☐ Unknown

8. Was the participant wearing a CGM sensor at the time of the event (either alone or as part of an automated insulin delivery system?

☐ Yes ☐ No ☐ Unknown

8a. If *Yes*, what was the glucose reading at the time the event was identified?

_____ ☐ mg/dL ☐ mmol/L ☐ Unknown

9. Was the participant wearing an automated insulin delivery system at the time of the event?

☐ Yes ☐ No ☐ Unknown

9a. If *Yes*, was the system in auto mode or manual mode?

☐ Auto Mode ☐ Manual Mode ☐ Unknown

10. Cause of Event

10a. Is there any evidence that a study device (e.g., blood glucose meter, CGM, and/or pump) contributed to the event (either device malfunction or improper use by user)?

☐ Yes ☐ No

If *Yes*, please complete a Device Issues Form.

10b. Is there any indication of non-study-device-related factors that contributed to the occurrence of the event?

☐ Yes ☐ No

If *Yes*, explanation of contribution of non-study device-related factors to the event:

_____

_____

_____

11. Outcome

☐ Fully recovered ☐ Other ☐ Unknown

If *Other*, describe:

_____

_____

_____

12. In the judgment of the investigator, did the event meet study criteria listed above for DKA?

☐ Definitely

☐ Probably, based on available information

☐ No (i.e., Hyperglycemia event but not DKA)

☐ Cannot determine from available information

CITY Post-Randomization Final Status Form

Subject ID: _____ Namecode: _____

Complete this form to report a change in a participant's status prior to the completion of the protocol. Please contact the Jaeb Center before dropping a participant (except for death).

Reason participant's participation in the Study has ended.

Note: If participant is requesting to withdraw, make the appropriate selection based on whether the participant has formally withdrawn consent in writing.

☐ Participant/Parent requests to withdraw - did not withdraw consent in writing

☐ Participant/Parent requests to withdraw - formally withdrew consent in writing

☐ Lost to follow up – *detail efforts to contact participant in COMMENTS*

☐ Site withdraws participant – *indicate reason in COMMENTS*

☐ Death

If ***Death***, Adverse Event Form indicating the fatal event must be completed prior to submitting the Final Status Form.**

If ***Participant/parent requests to withdraw***, select all reasons that apply and provide additional details in comments:**

Reason for participant/parent withdrawal:

☐ Adverse event

☐ Changed doctor

☐ Does not want study treatment and unwilling to be followed

☐ Finances

☐ Changed insurance

☐ Moved

☐ Other treatment requested and unwilling to be followed

☐ Poor health

☐ Poor outcome

☐ Scheduling/availability issues

☐ Travel difficulty

☐ Visit too lengthy

☐ Unknown

****If reason is not listed, please contact the Coordinating Center. Participants who discontinue use of study treatment should NOT be withdrawn from the study unless unwilling to continue to be followed by study team.**

WITHDRAWAL REASON COMMENTS
_____ _____ _____ _____
If reason for withdrawal is *Death*, complete the following: **Date of Death:** _____ _____ / _____ _____ / _____ _____ _____ _____ (mm/dd/yyyy) **Cause of Death:** _____ _____ / _____ _____ / _____ _____ _____ _____ (mm/dd/yyyy)