(OFFICE USE ONLY - SITE STAFF TO COMPLETE)

SECTION 1

Patient ID

Site ID

Individual Healthcare Identifier (IHI)

SECTION 2

Affix patient label here (if available) instead of completing patient details.

Title Miss Ms Mrs Mr Dr Master Other _____

First name

Surname

Date of birth D D / M M / Y Y Y Y

Sex at birth Female Male Other

Residential Address
Address Line 1

Address Line 1

Suburb

State

Postcode

Patient ID | Site ID | Staff Initials (optional)

Participant information sheet given (Note: Data will only be included in the ADCQR if this box is marked)

Mark box like this X

1.0 How was the consultation conducted? In person Video Phone

SECTION 1. PATIENT DEMOGRAPHICS

1.1 Date of birth D D / M M / Y Y Y Y

1.2 Sex Male Female → 1.2.1 Currently pregnant Yes No
Other

1.3 Date of visit D D / M M / Y Y Y Y

1.4 NDSS registrant Yes No

1.5 Aboriginal/Torres Strait Islander Yes No

1.6 Initial visit Yes No

1.7 Interpreter required Yes No

1.8 Main language spoken at home

1.9 DVA Yes No

1.10 Country of birth

1.11 Residential postcode

SECTION 2. DIABETES TYPE & MANAGEMENT

2.1 Date of diagnosis M M / Y Y Y Y

2.2 Type of diabetes Type 1 Type 2 Other (MODY, LADA, Pancreatic and other secondary causes) Don't know

2.3 Self-monitoring of glucose (Select all that apply)

None

Finger pricking →

2.3.1 Does the patient check as often as recommended? Yes No Unsure of recommended frequency

2.3.2 How many times a day?

Continuous Glucose Monitoring →

2.3.3 Was the sensor worn ⩾14 days in the last 3 months? Yes No

↳ 2.3.3.1 If YES, percentage of time sensor was active? <70% ⩾70%

2.4 Glycaemic management method (Select all that apply)

Diet only Metformin SGLT2 inhibitor GLP1/GIP agonist DPP4 inhibitor

Insulin Sulphonylurea Thiazolidinedione Acarbose

↳ 2.4.1 Insulin duration years and/or months →

2.4.2 Insulin mode (Select all that apply) Basal inj Bolus inj Pre-mixed insulin inj

Pump → Automated Manual

SECTION 3. WEIGHT & HEIGHT (MEASURED IN CLINIC OR SELF-REPORTED)

3.1 Weight . kg

3.2 Height . m

SECTION 4. BLOOD PRESSURE

4.1 Blood pressure / mmHg → 4.1.1 Measured in clinic OR Self-reported

4.2 Antihyperstensive treatment Yes No →

4.2.1 If YES (Select all that apply) ACE inhibitor Ca^{2+} channel blocker ARB
Beta blocker Thiazides/Diuretics Other

SECTION 5. BLOOD GLUCOSE CONTROL & RENAL FUNCTION (MOST RECENT IN LAST 12 MONTHS)

5.1 HbA1c result . % OR Not tested

5.1.1 HbA1c test date M M / Y Y Y Y

5.2 eGFR mL/min per 1.73m² OR Not tested

5.3 Serum creatinine µmol/L OR Not tested

5.4a Urinary albumin . mg/L ratio OR Not tested

5.4b Urinary protein . mg/L ratio OR Not tested

SECTION 6. MEDICATIONS & LIPIDS

6.1 Aspirin Yes No

6.2 Other antiplatelets Yes No

6.3 Anticoagulants Yes No

6.4 Lipid modifying therapy Yes No

↳ 6.4.1 If YES (Select all that apply) Statin Ezetimibe Fibrate PCSK9 inhibitor Fish oil

6.5 Lipids measured Yes No

↳ If YES, complete below:

6.5.1 Total cholesterol . mmol/L OR Not tested

6.5.2 LDL . mmol/L OR Not tested

6.5.3 HDL . mmol/L OR Not tested

6.5.4 Triglycerides . mmol/L OR Not tested

Patient ID Site ID

SECTION 7. DIABETES RELATED EYE & FOOT COMPLICATIONS

	Ever reported			If EVER REPORTED, was the complication diagnosed in the last 12 months?	
7.1 Retinopathy	Yes	No	If YES →	Yes	No
7.2 Treatment for retinopathy	Yes	No	If YES →	Yes	No
7.3 Right or left cataract	Yes	No	If YES →	Yes	No
7.4 Blindness	Yes	No	If YES →	Yes	No
7.5 Peripheral neuropathy	Yes	No	If YES →	Yes	No
7.6 Foot ulceration	Yes	No	If YES →	Yes	No
7.7 Lower limb amputation	Yes	No	If YES →	Yes	No
7.7.1 If YES (Select all that apply)		Minor Major		Minor Major	
7.7.2 If YES (Select ONE)		Unilateral Bilateral		Unilateral Bilateral	

SECTION 8. OTHER COMPLICATIONS/EVENTS/COMORBIDITIES

	Ever reported			If EVER REPORTED, was the complication diagnosed in the last 12 months?	
8.1 Cerebral stroke	Yes	No	If YES →	Yes	No
8.2 Myocardial infarction	Yes	No	If YES →	Yes	No
8.3 CABG/Angioplasty	Yes	No	If YES →	Yes	No
8.4 Heart failure	Yes	No	If YES →	Yes	No
8.5 Peripheral arterial disease	Yes	No	If YES →	Yes	No
8.6 End stage kidney disease	Yes	No	If YES →	Yes	No
8.7 Liver disease	Yes	No	If YES →	Yes	No
8.8 Sexual dysfunction	Yes	No	If YES →	Yes	No
8.9 Dementia	Yes	No	If YES →	Yes	No
8.10 Depression	Yes	No	If YES →	Yes	No
8.11 Anxiety	Yes	No	If YES →	Yes	No
8.12 Malignancy (exclude non-melanotic skin cancers)	Yes	No	If YES →	Yes	No
8.13 Diabetic ketoacidosis (DKA)	Yes	No	If YES →	Yes	No
8.14 Hyperosmolar hyperglycaemic state (HHS)	Yes	No	If YES →	Yes	No
8.15 Impaired awareness of hypoglycaemia	Yes	No	If YES →	Yes	No
8.16 Severe hypoglycaemia	Yes	No	If YES →	Yes	No
8.16.1 If YES, number of episodes				1-2 3-5 >5	

SECTION 9. MENTAL HEALTH SCREENING *(IF NOT PREVIOUSLY DIAGNOSED IN THE LAST 12 MONTHS)*

9.1 Has the patient been screened for diabetes distress in the last 12 months using a validated measure? Yes No
(e.g. PAID, DDS)

9.2 Has the patient been screened for depression in the last 12 months using a validated measure? Yes No
(e.g. PHQ-9)

9.3 Has the patient been screened for anxiety in the last 12 months using a validated measure? Yes No
(e.g. GAD-7)

SECTION 10. VACCINATION STATUS

10.1 Which of the following vaccinations is the patient currently up to date with? (Select all that apply)

Flu (Influenza) COVID-19 Pneumococcal Respiratory syncytial virus (RSV)

Please indicate whether the patient health and well-being questionnaire will be completed?

Yes → Please complete the questionnaire on page 3

No → Thank you for completing the ADCQR data collection form

(OFFICE USE ONLY - Site staff to complete Patient ID) **Patient ID** **Site ID**

Please answer all questions by marking the appropriate box **Mark box like this X**

SECTION 1. SMOKING STATUS

1.1 Do you currently smoke tobacco? ☐ Yes ☐ No → **If NO, did you previously smoke tobacco?** ☐ Yes ☐ No
[i.e. cigarettes/cigars/e-cigarettes (vaping)]

SECTION 2. HEALTH PROFESSIONAL ATTENDANCES

2.1 Have you seen an Endocrinologist - Diabetes Specialist in the last 12 months?	☐ Yes	☐ No
2.2 Have you seen a Diabetes Educator/Nurse Practitioner in the last 12 months?	☐ Yes	☐ No
2.3 Have you seen a Dietitian in the last 12 months?	☐ Yes	☐ No
2.4 Have you seen an Ophthalmologist/Optometrist in the last 12 months?	☐ Yes	☐ No
2.5 Have you seen a Psychologist/Psychiatrist in the last 12 months?	☐ Yes	☐ No
2.6 Have you seen a Dentist in the last 12 months?	☐ Yes	☐ No
2.7 Have you needed an Ambulance for your diabetes in the last 12 months?	☐ Yes	☐ No
2.8 Have you attended the Emergency Department for your diabetes in the last 12 months?	☐ Yes	☐ No

SECTION 3. MEDICATION USE

3.0 ***Please indicate how often each of the following statements applies to you when taking your prescribed medication. Tick one box for each statement.***

	Always	Often	Sometimes	Rarely	Never
3.1 I forget to take my medicine.	☐	☐	☐	☐	☐
3.2 I alter the dose of my medicine.	☐	☐	☐	☐	☐
3.3 I stop taking my medicine for a while.	☐	☐	☐	☐	☐
3.4 I decide to miss out a dose.	☐	☐	☐	☐	☐
3.5 I take less medicine than instructed.	☐	☐	☐	☐	☐

SECTION 4. FOOT CARE

4.1 Have you had your feet checked by a health professional in the last 12 months? ☐ Yes ☐ No

4.2 How often do you self check your feet? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/Never

SECTION 5. NUTRITION/DIET MANAGEMENT

5.1 Do you know what foods are best to eat?	☐ Yes	☐ No
5.2 Do you have enough time to prepare healthy meals?	☐ Yes	☐ No
5.3 Does it cost too much to eat healthy meals?	☐ Yes	☐ No
5.4 If you have type 1 diabetes - Do you find it hard to count carbs/weigh food?	☐ Yes	☐ No

SECTION 6. PHYSICAL ACTIVITY

6.1 How many minutes per week of moderate or vigorous intensity physical activity do you usually do?
(e.g. brisk walking, lawnmowing, swimming, or more vigorous activity such as jogging)

☐ **150 mins/week or more**
☐ **Less than 150 mins/week**
☐ **I rarely/never do moderate or vigorous physical activity**

6.2 Do you do any muscle strengthening exercise in a usual week? ☐ Yes ☐ No
(e.g. lifting weights or household tasks that involve lifting, carrying or digging)

SECTION 7. PROBLEM AREAS IN DIABETES (PAID-1) SCALE

7.1 How much of a problem is worrying about the future and the possibility of serious diabetes-related complications for you?

Not a problem	Minor problem	Moderate problem	Somewhat serious problem	Serious problem
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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Please answer all questions by marking the appropriate box **Mark box like this X**

SECTION 8. HEALTH RELATED QUALITY OF LIFE (EQ-5D-5L)

8.0 Under each heading, please tick the ONE box that best describes your health TODAY.

8.1 MOBILITY

- I have no problems with walking around
- I have slight problems with walking around
- I have moderate problems with walking around
- I have severe problems with walking around
- I am unable to walk around

8.2 PERSONAL CARE

- I have no problems with washing or dressing myself
- I have slight problems with washing or dressing myself
- I have moderate problems with washing or dressing myself
- I have severe problems with washing or dressing myself
- I am unable to wash or dress myself

8.3 USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

8.4 PAIN / DISCOMFORT

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

8.5 ANXIETY / DEPRESSION

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.
PLEASE RETURN TO STAFF.