



27311

Hospital ID: Site Staff ID: Participant ID: 

## **DRP: Diabetes Renal Project (Doctors Survey - Health Indicators)**

Thank-you for participating in this large multi-centre research project, called the Diabetes Renal Project (DRP). This National Health and Medical Research Council (NHMRC) partnership project is being conducted by Monash University, in partnership with Monash Health, Alfred Health, Royal North Shore Hospital, Concord Repatriation General Hospital, The George Institute for Global Health, Diabetes Australia, and Kidney Health Australia.

### **INSTRUCTIONS**

#### **PLEASE:**

Use a black **BIRO**, (DO NOT use a pencil or a fountain or felt tip pen)

Please **PRINT** in **CAPITAL** letters and stay within the box provided for text.

If you make a **mistake when writing**, cross it out with one thick line and write your correct answer above the box.

To answer a multiple choice question place a **CROSS INSIDE** the box like this:

If you make a **mistake**, place a diagonal line through the incorrect answer like this:  and then put a cross in the box of your preferred response.

Write dates using leading zeros (e.g. **6th April 2011 = 06/04/2011**)

**DO NOT USE** liquid paper to correct mistakes.

**AVOID** folding the form.

Please complete every page of the questionnaire. Sometimes questions may seem very similar or repetitious but they are all a little different, so please answer each question.

**THANK YOU**



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Date [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
day month year

### Health Indicators (Doctors Survey)

#### Section 1: Demographic of Patient Participant

- 1. Age (years) [ ][ ]
- 2. Gender  Male  Female
- 3. Participant Post-code [ ][ ][ ][ ][ ]
- 4. Aboriginal background  No  Yes
- 5. Torres Strait Islander background  No  Yes
- 6. Maori/Pacific Strait Islander background  No  Yes
- 7. Is the participant a current smoker ?  
 No → Skip to Q 8  
 Yes → 7.1. Average number of cigarettes smoked per day? [ ][ ]
- 8. Has the participant previously smoked ?  
 No → Skip to Q 9  
 Yes → 8.1. Average number of cigarettes smoked per day? [ ][ ]
- 9. Does the participant currently drink alcohol?  
 No → Skip to Q 10  
 Yes → 9.1. Average number of standard drinks per week? [ ][ ]

#### Section 2: Examination Findings

Please complete with the most recent examination findings and date of examination

10. Blood Pressure - (the average of 3 readings measured after 5 minutes sitting)

[ ][ ][ ] / [ ][ ][ ] mmHg → 10.1 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
day month year

11. Heart Rate [ ][ ][ ] Bpm → 11.1 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
day month year

12. Weight [ ][ ][ ][ ] . [ ][ ] Kg → 12.1 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
day month year

13. Height [ ][ ] . [ ][ ][ ] Metres → 13.1 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
day month year

At the most recent examination, does the participant have the following conditions:

14a. New loss of vibratory sensation (both feet)

No  Yes → Date of examination 14a.1 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
 Not examined/unknown day month year

14b. New loss of ankle reflexes (both legs)

No  Yes → Date of examination 14b.1 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
 Not examined/unknown day month year

14c. New loss of light touch (eg. loss of pressure sensation with 10gm force monofilament)

No  Yes → Date of examination 14c.1 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]  
 Not examined/unknown day month year



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**Section 2: Examination Findings (cont)**

**15. Foot ulcers**

No  Yes → Date of examination 15.1

/  /

Not examined/unknown

**16. Foot deformity**

No  Yes → Date of examination 16.1

/  /

Not examined/unknown

**Section 3: Medical History**

17. Diabetes Type  Type 1  Type 2 18. Duration of diabetes  years  months  
OR  Unknown/not documented

**Has the participant experienced any of the following complications/comorbidities?**

19. Ischemic Heart Disease?  No  Yes 23. Peripheral Neuropathy?  No  Yes  
20. Stroke?  No  Yes 24. Diabetic Nephropathy?  No  Yes  
21. Peripheral Vascular disease?  No  Yes 25. Hypertension  No  Yes  
22. Diabetic Retinopathy?  No  Yes 26. Dyslipidemia  No  Yes  
27. Does the participant have a family history of heart disease?  No  Yes  
OR  Unknown/not documented

28. Duration of nephrological care  years  months OR  Unknown/not documented

29. Kidney disease stage (select one option)  Stage 3a  Stage 3b  Stage 4  Stage 5

**30. Is the patient currently on dialysis?**

No → Skip to Q 31

Yes → 30.1 Haemodialysis  No  Yes → 30.2 Number of months on dialysis

30.3 Peritoneal  No  Yes → 30.4 Number of months on dialysis



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day month yearDate ceased **31.3**  /  /   
day month year**31.4 Peritoneal dialysis?** No  YesDate commenced **31.5**  /  /   
day month yearDate ceased **31.6**  /  /   
day month year**32. Has the patient had a kidney transplant?** No → Skip to Q 33 Yes → **32.1 Date of transplant**  /  /   
day month year**OR**  Unknown/not documented**Section 4: Medical Care of Diabetes and Chronic Kidney Disease****33. How often does the participant monitor his/her diabetes with a blood glucose monitor? (select one option)** ≥ 3 times per day  Once per day (daily)  Once per week (weekly)  Uncertain  
 2 times per day  A few times per week  Rarely  Not documented**34. Please indicate when the participant was last referred/seen by the following health professionals. (Select the appropriate response for each health professional).**

	Not referred/reviewed by this health professional	3 months or less	4-12 months ago	13-24 months ago	As required	Uncertain
a. Endocrinologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Nephrologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Diabetes Nurse Educator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Renal Nurse Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Optometrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Ophthalmologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Hospital ID: Site Staff ID: Participant ID: **Section 5: Medications****35. Is the participant on Insulin?** No → Skip to Q 36 Yes → **35.1 Is the participant on an Insulin pump?**  No  Yes**35.2 What type of insulin? (select all that apply)** Long acting  Short acting  Rapid acting  Basal**36. Is the participant on diabetes tablets?** No → Skip to Q 34 Yes → **Does the participant take:****36.1 Metformin?**  No  Yes**36.2 Sulphonylurea?**  No  Yes**36.3 Glitazone?**  No  Yes**36.4 Acarbose?**  No  Yes**36.5 Gliptin (DPP4 inhibitor)?**  No  Yes**36.6 GLP1 agonist?**  No  Yes  
(e.g exenatide or liraglutide)**36.7 SGLT2 inhibitors?**  No  Yes**36.8 Other diabetes medication (please list below)****37. Other medications - is the participant taking:****37.1 ACE inhibitor?**  No  Yes**37.2 Angiotensin2 Receptor Blocker?**  No  Yes**37.3 Other Antihypertensives?**  No  Yes**37.4 Statin?**  No  Yes**37.5 Fibrate?**  No  Yes**37.6 Erythropoieting Stimulating Agent?**  No  Yes**37.7 Phosphate binder?**  No  Yes**37.8 Iron Supplementation (IV or Oral)?**  No  Yes



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Hospital ID: Site Staff ID: Participant ID: **Section 6: Investigations**38. Has a HbA1c test been performed in the last 3 months?  No  Yes*Please record the most recent HbA1c result*38.1 HbA1c   mmol/mol **and** 38.2 . % → 38.3 Date of test  /  /   
day month year

39. Please enter details below of the most recent lipid profile results:

39.1 Total Cholesterol . mmol/L39.2 LDL Cholesterol . mmol/L39.3 HDL Cholesterol . mmol/L39.4 Triglycerides . mmol/L39.5 Date of test  /  /   
day month year**OR**  Not tested

40. Please enter details below of the most recent serum biochemistry profile results:

40.1 Potassium . mmol/L40.2 Creatinine  μmol/L40.3 Calcium . mmol/L40.4 Phosphate . mmol/L40.5 Parathyroid hormone (PTH) .  
(result within last 6 months)40.5.1 Units  pmol/L  ng/L**OR**  Not done within  
the past 6 months40.6 eGFR  mL/min per 1.73m<sup>2</sup>40.7 Albumin  g/L40.8 Date of test  /  /   
day month year

(For PTH, please record result from within the past 6 months of this date)

**OR**  Not tested

41. Please record the most recent spot urine albumin / creatinine ratio (ACR):

. mg/mmol 40.1 Date of test  /  /   
day month year **OR**  Not tested

42. If you have used another method to measure microalbumin / proteinuria please record details below:

. 42.1 Units  mg/L  mg/24hr  μg/min  g/mmol  g/L42.2 Date of test  /  /   
day month year **OR**  Not tested

43. Please enter the most recent Haemoglobin test result:

 g/L 43.1 Date of test  /  /   
day month year**OR**  Not tested