The ABCD prospective nationwide oral semaglutide audit is an independent audit supported by an unrestricted grant from Novo Nordisk Ltd

ABCD prospective nationwide oral semaglutide audit – visit 1 data collection form

Date / / (dd/mm/yyyy)

Name of clinician

Email

Hospital name

Hospital postcode

Centre I.D.

I confirm that I have entered this data accurately, as provided by the patient and test results _____ Signature

Patient identification

Please record patient name, gender and date of birth below
OR
AFFIX PATIENT LABEL HERE

Patient name

Gender ♂ Male ♀ Female (circle one)

Date of birth / / (dd/mm/yyyy)

White ☐

Afro-Caribbean ☐

Asian/Indian ☐

Baseline medical history

Duration of diabetes (in years) at this visit (yy)

Does the patient have a job that would be (or has been) affected by going on insulin (e.g. professional driver)? **Yes** **Not as far as I am aware** (circle one)

If **'Yes'** please give details including type of licence if appropriate. Licence types include:
- PCV (Passenger Carrying Vehicle) subdivided into category B (taxi/private hire) or D1 (minibus up to 16 seats)
- C/CE (large goods vehicles)
- C1/C1E (lorries)

Test Results (test dates **MUST** be entered for all tests where results are reported (dd/mm/yyyy))

HbA1c please enter **either** % % Date of test

or mmol/mol in correct cell mmol/mol

Blood pressure SBP mmHg Date of test

DBP mmHg

Previous vascular disease Circle 'Yes' or 'No' **Yes** **No** If yes, specify which

Cerebrovascular (stroke/transient ischaemic attack) ☐

Cardiovascular disease (angina/myocardial infarction/ coronary bypass graft/stent) ☐

Peripheral vascular disease (angioplasty/stent/intermittent claudication) ☐

Atrial fibrillation (If unsure assume no AF) Yes ☐ No ☐

Date If uncertain of exact date insert best guess / approximation.

Height metres Date of test

Current weight kg Date of test

BMI will be auto-calculated when data is entered into audit spreadsheet

Alanine aminotransferase - ALT IU/L Date of test

Urine albumin: creatinine ratio mg/mmol (ACR) Date of test

Triglyceride mmol/L Date of test

HDL mmol/L Date of test

Total cholesterol mmol/L Date of test

Serum creatinine µmol/L Date of test

Ophthalmology Is the patient under ophthalmology care? Circle 'Yes' or 'No' **Yes** **No** If yes, please comment on the current degree of retinopathy if known

Result of last retinopathy assessment (if known) Date of screening: If not known please enter best guess

Result of screening

Visual acuity:	Not known	6/6	6/9	6/12	6/18	6/24	6/36	6/48	6/60	6/CF	6/HM	6/PL	6/NPL	Circle one
Left Eye														
Right Eye														

Retinopathy screening grade:

Left Eye – Circle one		Right Eye – Circle one	
U - Ungradable	R2M1 Pre-proliferative diabetic retinopathy with maculopathy	U - Ungradable	R2M1 Pre-proliferative diabetic retinopathy with maculopathy
NA - Unknown	R3AM0 Acute proliferative retinopathy	NA - Unknown	R3AM0 Acute proliferative retinopathy
R0M0 No diabetic retinopathy	R3SM0 Stable proliferative retinopathy	R0M0 No diabetic retinopathy	R3SM0 Stable proliferative retinopathy
R1M0 Background diabetic retinopathy	R3AM1 Acute proliferative retinopathy with maculopathy	R1M0 Background diabetic retinopathy	R3AM1 Acute proliferative retinopathy with maculopathy
R1M1 Background retinopathy with maculopathy	R3SM1 Stable proliferative retinopathy with maculopathy	R1M1 Background retinopathy with maculopathy	R3SM1 Stable proliferative retinopathy with maculopathy
R2M0 Pre-proliferative diabetic retinopathy		R2M0 Pre-proliferative diabetic retinopathy	

Smoking

Never smoked ☐ Smoked some of their life (Partial) ☐ Smoker ☐

Antidiabetic treatment before initiation of oral semaglutide

Circle 'Yes' or 'No"

Is the patient switching to oral semaglutide from another GLP-1 receptor agonist? **Yes** **No** If yes, specify which

GLP-1 receptor agonist — Drug name: exenatide | exenatide qw | lixisenatide | dulaglutide | liraglutide | injectable semaglutide

Please circle the drugs that the patient is on

Metformin	Yes / No	Yes = 1; No=0	Score
Sulphonylurea	Yes / No	If yes, < half max. dose (Score 1); half max. dose (Score 2); > half max. dose – < full dose (Score 3); Full dose (Score 4)	Score
Pioglitazone	0mg / 15mg / 30mg / 45mg / No		
Meglitinides	Yes / No	Yes = 1; No=0	Score
Alpha-glucosidase inhibitors	Yes / No	Yes = 1; No=0	Score
SGLT2 inhibitors	Yes / No	Yes = 1; No=0	Score
DPP-4 inhibitors	Yes / No	Yes = 1; No=0	Score
Total dose of insulin			Total Dose IU/day
Other antidiabetic medications or medications which could affect glycaemic control — Drug name	*(freetext box)*		
Anti-obesity medication — Drug name: orlistat		Yes = 1; No=0	Score

Initiation of oral semaglutide

Date of initiation of oral semaglutide (dd/mm/yyyy) / /

Reason for using semaglutide: HbA1c ☐ Weekly convenience ☐ Other - please specify ☐ Weight ☐ Cardiovascular benefit ☐

Reason for using oral semaglutide if 'Other' selected

Starting dose of oral semaglutide: 3 7 14 (circle one) mg/day

Change in other antidiabetic medication?	Yes / No	**If yes** please cross out the drug class you are changing from and circle the drug class you are changing to	
Metformin	Yes / No	Yes = 1; No=0	Score
Sulphonylurea	Yes / No	If yes, < half max. dose (Score 1); half max. dose (Score 2); > half max. dose – < full dose (Score 3); Full dose (Score 4)	Score
Pioglitazone	0mg / 15mg / 30mg / 45mg / No		
Meglitinides	Yes / No	Yes = 1; No=0	Score
Alpha-glucosidase inhibitors	Yes / No	Yes = 1; No=0	Score
SGLT2 inhibitors	Yes / No	Yes = 1; No=0	Score
DPP-4 inhibitors	Yes / No	Yes = 1; No=0	Score
Total dose of insulin			Total Dose IU/day
Other antidiabetic medications or medications which could affect glycaemic control — Drug name	*(freetext box)*		
Anti-obesity medication — Drug name: orlistat		Yes = 1; No=0	Score

Any other comments?