ABCD prospective nationwide tirzepatide audit – follow up visit data collection form

Association of British Clinical Diabetologists

Name _____   Date of visit (dd/mmm/yyyy) _____

NHS Number _____

Date of Birth _____

Male ☐   Female ☐

Clinician name _____
Centre name _____
Centre ID _____

Most recent measurements:
Height _____ m
Weight _____ kg
BMI _____ kg/m^2
Waist circ. _____ cm
Date _____ dd/mmm/yyyy

Please provide separate height and weight measurements if they are available, rather than BMI, because the formula for calculating eGFR requires weight

Current tirzepatide dose

If tirzepatide has been stopped, state the date of stopping: _____ dd/mmm/yyyy and circle the reason(s) for stopping:

Insufficiently effective	Adverse effect(s)*	Other (state below)*	Unknown
* Please provide further detail of any adverse effects that preceded cessation of treatment in the dedicated section below		*** Brief details of any "Other" reason(s) for treatment cessation:**	

If tirzepatide treatment continues, please circle the current dose (mg/week):

2.5 mg	5 mg	7.5 mg	10 mg	12.5 mg	15 mg

Adverse effects? Circle any relevant, and provide further information beneath:

Gastrointestinal	Hypoglycaemia*	Other (state below)*	None	Unknown
*If you have chosen "Hypoglycaemia" did the patient experience Level 3 hypoglycaemia, defined as a severe event characterised by altered mental and/or physical functioning that requires assistance from another person for recovery, irrespective of glucose level? **Circle your response:**	Yes No Unknown		Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.	
*Give brief detail of any "Other" adverse effect(s):				

Test results (last dates **MUST** be entered for all tests where results are reported, using dd/mmm/yyyy format)

HbA1c	please enter either %	_____ %	Date of test _____
	or mmol/mol	_____ mmol/mol	

Total cholesterol	_____ mmol/L	Date of test _____	Serum creatinine	_____ µmol/L	Date of test _____
HDL cholesterol	_____ mmol/L	Date of test _____	ALT	_____ IU/L	Date of test _____
Triglycerides	_____ mg/mmol	Date of test _____	Urine ACR	_____ mg/mmol	Date of test _____

Diabetic retinopathy
- Yes ☐ Date of last check ☐
- No ☐
- Don't know ☐
- What was the last grade? Circle choices to the right

England/Wales/NI system		Scotland system	
Right eye R0	R0 **Left eye**	**Right eye** R0	R0 **Left eye**
R1	R1	R1	R1
R2	R2	R2	R2
R3A	R3A	R3	R3
R3S	R3S	R4	R4
and	*and*	R6	R6
M0	M0	*and*	*and*
M1	M1	M0	M0
or	*or*	M1	M1
Ungradeable	Ungradeable	M2	M2
Uncertain	Uncertain		

Current Medication: tablets … and … insulin

Drug / Drug class	Current medication? Circle as appropriate			Disregard brand / type if more than one insulin prescribed, instead reporting combined values
	Yes	**No**	**Unknown**	
Metformin	Y	N	?	
Sulfonylurea	Y	N	?	Number of insulin injections (of all types) per day: _____
Pioglitazone	Y	N	?	
DPP4 inhibitor	Y	N	?	
SGLT2 inhibitor	Y	N	?	
Meglitinide	Y	N	?	Total daily insulin dose: _____ units
Acarbose	Y	N	?	

Clinician's perception of patient's satisfaction (rate using five-point scale below, circling your choice):

1 (negative)	2 (mildly negative)	3 (neutral)	4 (mildly positive)	5 (positive)	OR Unable to ascertain

Any other comments?