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

ABCD prospective nationwide semaglutide audit – visit 1 data collection form

Date	/ / (dd/mm/yyyy)	Hospital name	
Name of clinician		Hospital postcode	
Email		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		Blood pressure SBP	mmHg	Date of test	
or mmol/mol in correct cell		mmol/mol			DBP	mmHg		

Circle 'Yes' or 'No"

Previous vascular disease **Yes** **No** If yes, specify which

Cerebrovascular (stroke/transient ischaemic attack)		Atrial fibrillation (If unsure assume no AF)	Yes		Date
Cardiovascular disease (angina/myocardial infarction/ coronary bypass graft/stent)			No		If uncertain of exact date insert best guess / approximation.
Peripheral vascular disease (angioplasty/stent/intermittent claudication)					

Height		metres	Date of test		Triglyceride	mmol/L	Date of test	
Current weight		kg	Date of test		HDL	mmol/L	Date of test	
BMI will be auto-calculated when data is entered into audit spreadsheet					Total cholesterol	mmol/L	Date of test	
Alanine aminotransferase - ALT		IU/L	Date of test		Serum creatinine	µmol/L	Date of test	
Urine albumin: creatinine ratio mg/mmol (ACR)			Date of test					

Smoking

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

Antidiabetic treatment before initiation of semaglutide

Circle 'Yes' or 'No"

Is the patient switching to 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

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 semaglutide

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

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

Reason for using semaglutide if 'Other' selected

Starting dose of semaglutide: 0.25 0.5 1.0 (circle one) mg/week

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?