ISLET TRANSPLANT APPLICATION FORM

INSTRUCTIONS:

This application and the information you provide will be used to determine if you are able to participate in an islet transplant trial at the Diabetes Research Institute. We will maintain your information in a secure location and it will be accessed only by our research staff. This information will not be reused or disclosed to any other person or entity, except as required by law. The information you will provide will be stored in our files for a period not to exceed ten (10) years. If you give us permission, even if you are not eligible, we would like to keep your information in our files.

CONSENT TO BE CONTACTED FOR CLINICAL TRIALS AT THE DIABETES RESEARCH INSTITUTE:

I,_____(Print Name) agree to be contacted by the Clinical Islet Transplantation Program (CITP) team regarding future clinical trials for which I may be eligible.

I also agree and consent that my name and contact information may be provided by the CITP to other departments at the Diabetes Research Institute for the purpose of clinical trial information and/or eligibility screening.

_____ _____ _____

Signature: **Date:** **Phone #**

Please complete the entire application form and mail it to us at:

Clinical Islet Transplant Program
Diabetes Research Institute
PO Box 016960 (R134)
Miami, FL 33101

You may fax a copy of the completed form to **305-243-1058,** but we ask that you also mail the original form to us. Be sure to keep copies for your records.

ISLET TRANSPLANT CANDIDATE INFORMATION FORM

Please read all questions carefully and complete *ALL* the pages. Print clearly and do not leave any blanks. Write N/A for any questions that do not apply.

Applicant's Personal Information (please print clearly).

1. Name (Last, MI, First)	2. Date of Birth(MM/DD/YY)	3. Age:	4. Gender: ☐ Male ☐ Female
5. Street Address			6. Occupation:
7. City	8. State/Prov	9. Zip/Postal Code	10. E-Mail Address
11. Home Telephone	12. Work Telephone	13. Cell Phone Number	14. Fax Number
15. Emergency Contact	16. Telephone	17. Relationship	18. How did you hear about us?

Complete this section (about yourself) *if you are entering the information for the*

19. Name (Last, First)		
20. Address, City, State, ZIP		
21. Telephone	22. Email Address	23. Relationship

Social Information

24. Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

25. Ethnic/Race Background: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White or Caucasian

26. Current weight:_____lbs. Your height:_____ft._____in.

27. Are you a current smoker? ☐ Yes ☐ No
If yes, enter number of cigarettes per day_____and for how long you have been smoking_____years

28. Do you have a history of smoking? ☐ Yes ☐ No
If yes, how many cigarettes per day did you smoke?_____ How many years did you smoke? _____
What year did you stop smoking? _____

29. Do you consume alcoholic beverages? ☐ Yes ☐ No
If yes, enter the average number of alcoholic beverages you drink per week _____
Type of beverage_____

30. Are you of childbearing age? ☐ Yes ☐ No If yes, are you currently: ☐ pregnant ☐ breast feeding
List any method of birth control you currently use: _____

Diabetes Information:			
31. Diabetes: ☐Type 1 ☐Type2	32. Date Diagnosed: Month/year_____	33. Age at Diagnosis: _____	34. Diabetes Duration:_____years

History of Diabetes Complications of the eyes, kidneys, nerves, cardiovascular & DKA

35. Do you have or have you ever had diabetic eye disease (retinopathy)? ☐ YES ☐ NO

If you answer "no" to the previous question, go to question #36.
If you answered "yes" to the previous question, please answer the following questions:

35.a. Which eye is/was affected? ☐ Left ☐ Right ☐ Both

35.b. What kind of retinopathy do you have? ☐Active proliferative ☐Stable proliferative ☐Non-proliferative

35.c. Have you ever had eye surgery (laser therapy or vitrectomy)? ☐ YES ☐

NO If yes, which eye?_____Date of procedure: _____

36. Do you have diabetic kidney disease (nephropathy)? ☐ YES ☐ NO

If you answer "no" to the previous question, go to question #37.
If you answered "yes" to the previous question, please answer the following questions:

36.a What kidney condition do you have? ☐ Elevated creatinine ☐ Microalbuminuria
☐ Moderate to severe proteinuria ☐ Kidney failure

36.b. Are you on dialysis? ☐ YES ☐ NO

36.c. Have you had a kidney transplant? ☐ YES ☐ NO

If Yes, date:_____Hospital/Surgeon:_____

37. Do you have diabetic nerve damage (neuropathy)? ☐ YES ☐ NO

37.a. If you answered "yes" to the previous question, please check all that apply:

☐ Numbness in hands/feet ☐ Sensory loss ☐ dizziness on standing ☐ rapid heartbeat at rest

☐ Nausea/Vomiting ☐ Diarrhea ☐ Bloating ☐ Problems with sexual function ☐ Other: _____

38. Do you have diabetic damage of the blood vessels (cardiovascular disease)? ☐ YES ☐ NO

38.a. If you answered "yes" to the previous question, please check all (treated and untreated) that apply:

☐ High blood pressure ☐ High cholesterol ☐ High triglycerides ☐ Low HDL ☐ High LDL

☐ Heart (heart attack/angina) ☐ Stroke/TIA ☐ Leg pain when walking (PVD/claudication)

☐ Bypass surgery ☐ Amputation (specify site):_____ ☐ Other: _____

39. Do you have unstable diabetes that has failed to respond to intensive insulin therapy as judged by an Endocrinologist or Diabetologist? ☐ YES ☐ NO

40. . Have you ever had diabetic Ketoacidosis (DKA) or high blood sugar with ketones requiring hospitalization? ☐ YES ☐ NO

40.a. If you answered "yes" to DKA, how many times in the past year? _____

History of Diabetes Complications, Hypoglycemia	
41. Do you suffer from frequent low blood sugars that result in loss of consciousness?	☐ YES ☐ NO
42. Do you have hypoglycemia unawareness? (inability to sense when your blood sugar is low)	☐ YES ☐ NO
Hypoglycemia score (recall)	
43. Have you ever needed help from someone else to **recognize** a low blood sugar?	☐ YES ☐ NO
43.a. If you answered, "yes" to the previous question, how many times has this occurred in the last 12 months?	_____
44. Have you ever needed help from someone else to **treat** a low blood sugar?	☐ YES ☐ NO
44.a. If you answered, "yes" to the previous question, how many times has this occurred in the last 12 months?	_____
45. Have you ever needed **glucagon** injections to treat a low blood sugar?	☐ YES ☐ NO
45.a. If you have answered, "yes" to the previous question, how many times has this occurred in the past 12 months?	_____
46. Have you ever been taken to an **Emergency Room** or had an **ambulance** called for you in order to treat a low blood sugar?	☐ YES ☐ NO
46.a. If you have answered, "yes" to the previous question, how many times has this occurred in the past 12 month?	_____

Clarke Hypoglycemia Survey:

47. Check category that best describes you (check one only)

☐ I always have symptoms when my blood sugar is low.
☐ I sometimes have symptoms when my blood sugar is low.
☐ I no longer have symptoms when my blood sugar is low.

48. Have you lost some of the symptoms that used to occur when your blood sugar was low?
☐Yes ☐ No

49. In the past 6 months, how often have you had hypoglycemia episodes (low blood sugar) where you felt confused, disoriented, or lethargic and were unable to treat yourself (required assistance from another person)?

☐Never ☐Once or twice ☐Every other month ☐Once a month ☐More than once a month

50. In the past 12 months, how often have you had hypoglycemia episodes (low blood sugar) where you were unconscious or had a seizure and needed glucagon injection or intravenous glucose?

Circle one 0 1 2 3 4 5 6 7 8 9 10 11 12 or more

51. How often, in the last month, have you had readings less than 70 mg/dl (3.9 mmol/L) WITH symptoms?

☐ Never ☐ 1-3 times ☐ 1 time/week ☐ 2-3 times/week ☐ 4-5 times/week ☐ Almost daily

52. How often, in the last month, have you had readings less than 70 mg/dl (3.9 mmol/L) WITHOUT symptoms?

☐ Never ☐ 1-3 times ☐ 1 time/week ☐ 2-3 times/week ☐ 4-5 times/week ☐ Almost daily

53. How low does your blood sugar go before you feel symptoms?

☐ Above 70 mg/dL ☐ 60 – 69 mg/dL ☐ 50 – 59 mg/dL ☐ 40 – 49 mg/dL ☐ less than 40mg/dL

54. To what extent can you tell by your symptoms that your blood sugar is low?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Diabetes Management:

55. Are you under the care of an endocrinologist or diabetes specialist? ☐YES ☐NO

If yes, how many times have you visited him/her in the past year? _____

If no, who helps you look after your diabetes? _____

56. What is your last HbA1C result? _____ Date: _____

57. How many times a day do you test your blood sugars? _____

58. How do you administer your insulin? ☐ Insulin injection ☐ Insulin Pump

59. If you use insulin injections, please answer the following questions:

67.a. How many injections do you administer per day? _____

67.b. What is the average total insulin that you take per day? _____

60. If you use an insulin pump, please answer the following questions:

a. What is the average total BASAL INSULIN that you require per day? _____

b. What is the average total BOLUS insulin that you use per day? _____

61. Please Circle *all* the insulin preparations that you are currently using?

Rapid acting:	Short acting	Intermediate acting:	Long acting:	Mixed insulin:	Other: (write in if not listed)
Humalog/Lispro	Regular	NPH	Lantus/ Glargine	50/50	
Novolog/Aspart	Humulin R	Humulin N	Levemir/ Detemir	70/30	
Apidra/Glulisine	Novolin R	Novolin N		75/25	Non-Insulin
Exubera/ inhaled insulin					Symlin/ Pramlintide

In the tables below, list any significant illnesses other than diabetes and/or major surgeries you have had. *(Attach additional page, if necessary).*

62. Medical History Please list any relevant medical problems not listed in the previous sections of the form.

Major Illness	**Date Onset**	**Current Status** **	**Date Resolved**	**Treatment** (medication/surgery etc)

**Choose from the following options: *Active, Stable, Stable/treated, Intermittent, or Resolved*

63. Surgical History (Please print clearly)

Surgery	**Date**	**Outcome**	**Complications**

Additional Medical/ Surgical Background		
64. Do you have a history of liver disease?	☐ YES	☐ NO
65. Have you had any type of cancer including skin cancer?	☐ YES	☐ NO
66. If yes to the previous question, please explain:		
67. Have you ever had a transplant other than kidney?	☐ YES	☐ NO
68. If yes to the previous question, what organ(s)?		

In the table below, list any medications you are currently taking *(attach additional page, if necessary)*.

69. Current Medications (please print clearly)

Drug Name	Trade Name	Date Started	Dose	Units mg, etc.	Route	Fre-quency	Indication / Reason	Prescribed by

70. List known allergies to medications: _____

71. Referral Information (please print clearly)

How did you find out about this program?

☐ Doctor ☐ Newspaper ☐ Friend

☐ DRIwebsite ☐ Other patient ☐ Magazine ☐Other_____

If you were referred to us by a doctor, complete the information below.

72. Referring Physician (please print clearly)

Name (Last, MI, First include MD, PhD etc.)

☐ Family practitioner ☐ Internist ☐ Endocrinologist/Diabetologist

Address

City	State/Province	Zip/Postal Code	E-Mail Address (if known)

Work Telephone (if outside the US, include country code)	Fax Number

73. Primary Care Physician Information (please print clearly)			**If Referring Physician check here** ☐
Name (Last, MI, First include MD, ARNP, PhD etc.)	☐ Family practitioner ☐ Internist		
Address			
City	State/Province	Zip/Postal Code	E-Mail Address (if known)
Work Telephone (if outside the US, include country code)	Fax Number		

74. Endocrinologist/Diabetologist Information (please print clearly)			**If Referring Physician check here** ☐
Name (Last, MI, First include MD, PhD etc.)	☐ Family practitioner ☐ Internist ☐ Endocrinologist/Diabetologist		
Address			
City	State/Province	Zip/Postal Code	E-Mail Address (if known)
Work Telephone (if outside the US, include country code)	Fax Number		

I, print your name here, understand that by completing this form and returning it to the Diabetes Research Institute, I am granting the Diabetes Research Institute permission to use the information contained in this form for research purposes in islet transplantation.

Your records and results will be kept confidential to the extent permitted by law and according to current HIPAA guidelines. The Food and Drug Administration (FDA) and the Department of Health and Human Services (DHHS) may request to review and retain copies of these research records.

SIGNATURE: _____ **DATE:** _____

Note: If available, please include results from your last 24-hour urine collection and eye exam done within the last 6 months.

During the next 28 days of monitoring, complete one section of the diary below for each ***hypoglycemic event*** that meets the following criteria:

a. Any fingerstick glucose reading equal to or less than **54**mg/dl (**3.0**mmol/L)
b. Any symptoms of hypoglycemia even without a fingerstick reading

Answer **all** questions in the box and do not leave any blanks. Write N/A if not applicable.
If you do not have any episodes of hypoglycemia during the 28 days check this box. ☐

Date:_____Time:_____ Blood sugar Value:_____ **OR** Low

1. Symptoms felt or what did you notice? (Please circle <u>all</u> the symptoms you had)

Sweating Problems with Vision Seizure **OR** None
Shaking Change in behaviour Other _____
Heart palpitations Confusion _____

2. The reaction was recognized by (Please circle <u>one</u>):

Yourself Routine test on your meter Someone else

3. Treatment for the reaction needed (Please circle <u>all</u> that apply):

Juice/Food Help from someone else Injection of glucagon Hospital/Ambulance

Date:_____Time:_____ Blood sugar Value:_____ **OR** Low

1. Symptoms felt or what did you notice? (Please circle <u>all</u> the symptoms you had)

Sweating Problems with Vision Seizure **OR** None
Shaking Change in behaviour Other _____
Heart palpitations Confusion _____

2. The reaction was recognized by (Please circle <u>one</u>):

Yourself Routine test on your meter Someone else

3. Treatment for the reaction needed (Please circle <u>all</u> that apply):

Juice/Food Help from someone else Injection of glucagon Hospital/Ambulance

Date:_____Time:_____ Blood sugar Value:_____ **OR** Low

1. Symptoms felt or what did you notice? (Please circle <u>all</u> the symptoms you had)

Sweating Problems with Vision Seizure **OR** None
Shaking Change in behaviour Other _____
Heart palpitations Confusion _____

2. The reaction was recognized by (Please circle <u>one</u>):

Yourself Routine test on your meter Someone else

3. Treatment for the reaction needed (Please circle <u>all</u> that apply):

During the next 28 days of monitoring, complete one section of the diary below for each ***hypoglycemic event*** that meets the following criteria:

c. Any fingerstick glucose reading equal to or less than **54**mg/dl (**3.0**mmol/L)
d. Any symptoms of hypoglycemia even without a fingerstick reading

Answer **all** questions in the box and do not leave any blanks. Write N/A if not applicable.
If you do not have any episodes of hypoglycemia during the 28 days check this box. ☐

Date:_______________Time:__________________ Blood sugar Value:__________ **OR** Low

1. Symptoms felt or what did you notice? (Please circle all the symptoms you had)

Sweating	Problems with Vision	Seizure	**OR**	None
Shaking	Change in behaviour	Other ____________________		
Heart palpitations	Confusion	____________________		

2. The reaction was recognized by (Please circle one):

Yourself Routine test on your meter Someone else

3. Treatment for the reaction needed (Please circle all that apply):

Juice/Food Help from someone else Injection of glucagon Hospital/Ambulance

Date:_______________Time:__________________ Blood sugar Value:__________ **OR** Low

1. Symptoms felt or what did you notice? (Please circle all the symptoms you had)

Sweating	Problems with Vision	Seizure	**OR**	None
Shaking	Change in behaviour	Other ____________________		
Heart palpitations	Confusion	____________________		

2. The reaction was recognized by (Please circle one):

Yourself Routine test on your meter Someone else

3. Treatment for the reaction needed (Please circle all that apply):

Juice/Food Help from someone else Injection of glucagon Hospital/Ambulance

Date:_______________Time:__________________ Blood sugar Value:__________ **OR** Low

1. Symptoms felt or what did you notice? (Please circle all the symptoms you had)

Sweating	Problems with Vision	Seizure	**OR**	None
Shaking	Change in behaviour	Other ____________________		
Heart palpitations	Confusion	____________________		

2. The reaction was recognized by (Please circle one):

Yourself Routine test on your meter Someone else

3. Treatment for the reaction needed (Please circle all that apply):

Juice/Food Help from someone else Injection of glucagon Hospital/Ambulance

Diabetes Research Institute **1450 NW 10th Avenue, Miami, FL 33136**

Telephone: 305-243-5321 **or** 305-243-5557 **Fax** 305-243-1058

E-mail: Islet@med.miami.edu

Body Mass Index (BMI) Conversion Table

Height ↓		Weight →																								
Inches	Meters	kg	45.3	49.9	54.4	59.0	63.5	68.0	72.6	77.1	81.7	86.2	90.7	95.3	99.8	104.3	108.9	113.4	117.9	122.5	127.0	131.5	136.1
		lb	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300
55	1.40		23.24	25.56	27.89	30.21	32.54	34.86	37.19	39.51	41.84												
56	1.42		22.43	24.67	26.92	29.16	31.40	33.65	35.89	38.13	40.37	42.62											
57	1.45		21.64	23.80	25.96	28.13	30.29	32.46	34.62	36.79	38.95	41.12	43.28										
58	1.47		20.90	22.99	25.08	27.17	29.26	31.35	33.44	35.53	37.62	39.71	41.80	43.89									
59	1.50		20.20	22.22	24.24	26.26	28.28	30.29	32.32	34.33	36.35	38.37	40.39	42.41	44.43								
60	1.52		19.53	21.48	23.43	25.39	27.34	29.29	31.25	33.20	35.15	37.11	39.06	41.01	42.96	44.92	46.87	48.82	50.78	52.73	54.68	56.64	58.59
61	1.55		18.89	20.78	22.67	24.56	26.45	28.34	30.23	32.12	34.01	35.90	37.79	39.68	41.57	43.46	45.35	47.24	49.13	51.02	52.90	54.79	56.68
62	1.58		18.29	20.12	21.95	23.78	25.61	27.44	29.26	31.09	32.92	34.75	36.58	38.41	40.24	42.07	43.90	45.72	47.55	49.38	51.21	53.04	54.87
63	1.60		17.71	19.48	21.26	23.03	24.80	26.57	28.34	30.11	31.88	33.66	35.43	37.20	38.97	40.74	42.51	44.28	46.06	47.83	49.60	51.37	53.14
64	1.63		17.16	18.88	20.60	22.31	24.03	25.75	27.46	29.18	30.90	32.61	34.33	36.05	37.76	39.48	41.20	42.91	44.63	46.34	48.06	49.78	51.49
65	1.65		16.64	18.30	19.97	21.63	23.30	24.96	26.62	28.29	29.95	31.62	33.28	34.94	36.61	38.27	39.94	41.60	43.26	44.93	46.59	48.26	49.92
66	1.68		16.14	17.75	19.37	20.98	22.60	24.21	25.82	27.44	29.05	30.67	32.28	33.89	35.51	37.12	38.74	40.35	41.96	43.58	45.19	46.81	48.42
67	1.70		15.66	17.23	18.79	20.36	21.93	23.49	25.06	26.62	28.19	29.76	31.32	32.89	34.46	36.02	37.59	39.15	40.72	42.29	43.85	45.42	46.99
68	1.73		15.20	16.72	18.24	19.77	21.29	22.81	24.33	25.85	27.37	28.89	30.41	31.93	33.45	34.97	36.49	38.01	39.53	41.05	42.57	44.09	45.61
69	1.75		14.77	16.24	17.72	19.20	20.67	22.15	23.63	25.10	26.58	28.06	29.53	31.01	32.49	33.96	35.44	36.92	38.39	39.87	41.35	42.82	44.30
70	1.78		14.35	15.78	17.22	18.65	20.09	21.52	22.96	24.39	25.83	27.26	28.70	30.13	31.57	33.00	34.44	35.87	37.30	38.74	40.17	41.61	43.04
71	1.80			15.34	16.74	18.13	19.52	20.92	22.32	23.71	25.10	26.50	27.89	29.29	30.68	32.08	33.47	34.87	36.26	37.66	39.05	40.45	41.84
72	1.83			14.92	16.27	17.63	18.99	20.34	21.70	23.05	24.41	25.77	27.12	28.48	29.84	31.19	32.55	33.90	35.26	36.62	37.97	39.33	40.69
73	1.85			14.51	15.83	17.15	18.47	19.79	21.11	22.43	23.75	25.07	26.39	27.71	29.02	30.34	31.66	32.98	34.30	35.62	36.94	38.26	39.58
74	1.88			14.12	15.41	16.69	17.97	19.26	20.54	21.83	23.11	24.39	25.68	26.96	28.25	29.53	30.81	32.10	33.38	34.66	35.95	37.23	38.52
75	1.91				14.99	16.25	17.50	18.75	20.00	21.25	22.50	23.75	25.00	26.25	27.49	28.75	30.00	31.25	32.50	33.75	35.00	36.25	37.50
76	1.93				14.61	15.82	17.04	18.26	19.47	20.69	21.91	23.13	24.34	25.56	26.78	27.99	29.21	30.43	31.65	32.86	34.08	35.30	36.52

From Bray, GA, et al.: Evaluation of the obese subject. 1. An algorithm. JAMA, 235: 1487, 1976

Blood Sugar Record Data Sheet

Name: ____________________ **Date From:** ___/___/___ **to** ___/___/___ **Page 1**

Instructions

- *Two copies of the record data sheet will be provided. Both must be completed* ***for a total of 28 consecutive days*** *of blood glucose readings*
- *Record all glucose readings under the column that corresponds to the time of the reading and in the row that corresponds to the date of the reading.*
- *A minimum of 3 readings should be entered each day*
- *Record all insulin taken. For insulin type, see legend below. Enter basal rates and enter boluses (meal coverage or corrections) in the appropriate line/column*
- *For any blood sugar value under* ***54*** *mg/dl (****3.0*** *mmol/l), please complete a hypoglycemia questionnaire box on the hypoglycemia sheet*

		AM												PM												Line total	24 Hr total
DATE	TIME	1:00	2:00	3:00	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	1:00	2:00	3:00	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00		
	Blood Sugar																										
	Bolus Insulin																										
	Basal Insulin																										
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	Bolus Insulin																										
	Basal Insulin																										

INSULIN GUIDE		
N - NPH	L -Lantus	H- Humalog
P- Pump	R- Regular	Other:

NOTE: CITP ONLY, PLEASE LEAVE BLANK
Week: __________ /52 Year __________
Study ID:

AVERAGE DAILY INSULIN
________ /14 = ________

Diabetes Research Institute **1450 NW 10th Avenue, Miami, FL 33136**

Telephone: 305-243-5321 **or** 305-243-5557 **Fax** 305-243-1058

E-mail: Islet@med.miami.edu

Blood Sugar Record Data Sheet

Name: ____________________ **Date From:** ___/___/___ **to** ___/___/___ **Page 1**

Instructions

- *Two copies of the record data sheet will be provided. Both must be completed* ***for a total of 28 consecutive days*** *of blood glucose readings*
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- *A minimum of 3 readings should be entered each day*
- *Record all insulin taken. For insulin type, see legend below. Enter basal rates and enter boluses (meal coverage or corrections) in the appropriate line/column*
- *For any blood sugar value under* ***54*** *mg/dl (****3.0*** *mmol/l), please complete a hypoglycemia questionnaire box on the hypoglycemia sheet*

		AM												PM												Line total	24 Hr total
DATE	TIME	1:00	2:00	3:00	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	1:00	2:00	3:00	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00		
	Blood Sugar																										
	Bolus Insulin																										
	Basal Insulin																										
	Blood Sugar																										
	Bolus Insulin																										
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	Bolus Insulin																										
	Basal Insulin																										

INSULIN GUIDE		
N - NPH	L -Lantus	H- Humalog
P- Pump	R- Regular	Other:

NOTE: CITP ONLY, PLEASE LEAVE BLANK
Week: ________ /52 Year ________
Study ID:

AVERAGE DAILY INSULIN
________ /14 = ________

Diabetes Research Institute **1450 NW 10th Avenue, Miami, FL 33136**

Telephone: 305-243-5321 **or** 305-243-5557 **Fax** 305-243-1058

E-mail: Islet@med.miami.edu

PROOF OF MEDICAL INSURANCE(S)

Please be aware, that in order for you to be enrolled in the Clinical Islet Transplant Program, we must have proof of your medical insurance coverage for the past six months on file. Please complete the form below with your medical insurance information and ***attach a photocopy (back and front) of your current active insurance*** card (primary and secondary). Return this form and the photocopy of your card(s) with the Islet Transplantation Patient Evaluation Form to the address listed below:

Clinical Islet Transplant program
Diabetes Research Institute
PO Box 016960 (R134)
Miami, Fl 33101

Primary Insurance

Name of Primary Insurance: _____
Policy Number: _____
Policy Holder _____
Member(s) covered: _____
Insurance phone number: _____

Other/Secondary Insurance

Name of Secondary Insurance: _____
Policy Number: _____
Policy Holder: _____
Member(s) covered: _____
Insurance phone number: _____

PROOF OF MEDICAL CARE BY YOUR PRIMARY PHYSICIAN Of GREATER THAN 6 MONTHS

Date:_____/_____/_____

Name of Patient: _____

Name of Primary Care Physician: _____

Address: _____

_____

_____

Tel: _____

This letter is to confirm that I have been providing care to this patient for more than 6 months and continues to be under my medical care.

I support this patient's application for islet transplant clinical trials.

Sincerely,

_____

Signature of Primary Care Physician

_____/_____/_____

Date signed

PROOF OF MEDICAL CARE BY YOUR DIABETES CARE SPECIALIST (ENDOCRINOLOGIST OR DIABETOLOGIST) GREATER THAN 6 MONTHS

Date:_____/_____/_____

Name of Patient: _____

Name of Diabetes Care Specialist:

_____

Address: _____

_____

_____

Tel: _____

This letter is to confirm that I have been providing care to this patient for more than 6 months.

This patient has the following diabetes related problems:

- ☐ hypoglycemia unawareness
- ☐ severe hypoglycemia
- ☐ labile diabetes
- ☐ diabetes complications
  - ☐ retinopathy
  - ☐ nephropathy
  - ☐ neuropathy
  - ☐ gastroparesis
- ☐ cardiovascular disease
  If yes, please specify _____
- ☐ none of the above

I support this patient's application for islet transplant clinical trials

Sincerely,

_____

Signature of Diabetes Care Specialist

_____/_____/_____

Date signed

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