INSULIN PUMP
FOLLOW-UP FORM (Pages 1, 2 & 3 to be completed by patient/family)

NAME: ______________________________________

DATE: ______________________________________

To help us make the most of your visit, please take a few minutes to complete this form. Please do not fill in the shaded area on page 3 & page 4. If there are parts you are unsure of, please leave blank and discuss with your team.

What type of diabetes do you have? ☐ Type 1 ☐ Type 2

What is the biggest concern about caring for your diabetes that you wish to talk about today? What would you like to do during this visit to help you?

Are there other things you would like to talk about (please check the most important ones)?

☐ Diet/nutrition/Carb counting ☐ Weight ☐ Physical activity
☐ Diabetes medication/insulin ☐ Blood pressure ☐ Cholesterol
☐ Stress ☐ Low blood glucose ☐ Smoking
☐ Feet (foot care/problems) ☐ High blood glucose ☐ Street drugs
☐ Depression/mood changes ☐ Present symptoms ☐ Sexual Health
☐ Pump settings ☐ Prescriptions needed: ☐ insulin ☐ supplies ☐ strips
☐ Other: __________________________________________

ACTIVITY

What types of exercise/activity do you do? ☐ None

Please list: ______________________________________

What adjustments are made to insulin/food for exercise(s)?

☐ Temporary basal rates ☐ Suspend pump ☐ Carb coverage ☐ Decrease bolus
☐ Extra monitoring ☐ Other: ____________________________

HYPOGLYCEMIA

In the past 7 days, how many blood glucose values were less than 4 mmol/L? ________ ☐ None

In the past 30 days, how many blood glucose values were less than 4 mmol/L? ________ ☐ None

Any overnight lows? ☐ Yes ☐ No

What caused the lows? ☐ Activity ☐ Illness ☐ Correction ☐ Miscounted Carb ☐ Unknown

Since last DC visit, any lows that required help to treat? ☐ Yes ☐ No

Lows treated with: ____________________________________________

Glucagon kit? ☐ Yes ☐ No ☐ If no, why not? ____________________________
SELF-MONITORING OF BLOOD GLUCOSE (SMBG)

Type of glucose monitor: ________________________________

How often is BG checked? __________  □ Testing ≥ 4x/day

Are BG records kept?  □ Yes  □ No

If yes, how often are BG records reviewed? __________________________________________________________

Is insulin/food adjusted based on SMBG results?  □ Yes  □ No  If yes, please provide an example:

What are average BG values for the last 7 to 14 days?  □ See log book

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>AM Snack</th>
<th>Lunch</th>
<th>PM Snack</th>
<th>Supper</th>
<th>Bedtime</th>
<th>2300</th>
<th>0300</th>
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HIGH BLOOD GLUCOSE AND KETONES

Have you experienced pump failure or ketones since your last visit?  □ Yes  □ No

Do you have a ketone meter?  □ Yes  □ No  At what glucose level do you test for ketones? _____ mmol/L

How many episodes of DKA have you had since your last visit?  __________________________  □ None

Do you carry an emergency kit (batteries, insertion set, reservoirs, insulin, syringes, hypo treatment)?  □ Yes  □ No

What do you do if you become sick?  __________________________________________________________

GOALS

What is your personalized A1C goal?  __________  What steps have you taken to help achieve this goal?

What are your diabetes management goals for the next month?  ______________________________________

SEXUAL HEALTH

Are you sexually active?  □ Yes  □ No  If yes, are you using birth control?  □ Yes  □ No
INSULIN PUMP

Did you download your pump today? ☐ Yes ☐ No

Which insulin pump and infusion set do you use (please check)?

☐ Animas: ........... ☐ Inset-30° 13mm
☐ Medtronic: ...... ☐ Silhouette® mm
☐ Omni pod

Are your sites? ☐ Lumpy ☐ Bruised ☐ Sore ☐ Red ☐ No problems

Which sites do you use? ☐ Abdomen ☐ Hip ☐ Thigh ☐ Arm ☐ Other

How often is the insertion site changed? ☐ Daily ☐ Every 2-3 days ☐ Every 5 or more days

BASAL INSULIN: % ☐ Humalog® ☐ Novo Rapid® ☐ Apidra®

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<tr>
<th>Time</th>
<th>Rate</th>
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Do you use temporary basal rates? ☐ Yes ☐ No

BOLUS: % ☐ Do you use a bolus calculator? ☐ Yes ☐ No

Insulin-to-Carb Ratios

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<th>Time</th>
<th>Ratio</th>
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Blood Glucose Targets

<table>
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<tr>
<th>Time</th>
<th>BG Target</th>
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CURRENT TOTAL DAILY DOSE (TDD): _____ ISF: _____ ACTIVE INSULIN TIME: _____ hours

NUTRITION/DIET HISTORY (DIETITIAN WILL FILL OUT DURING VISIT)
## HYPOGLYCEMIA

<table>
<thead>
<tr>
<th>Date</th>
<th>Treated by:</th>
<th>Treated with glucagon (%)</th>
<th>What was the cause of moderate/severe hypoglycemia (note number): 1) Exercise; 2) Insulin error; 3) Missed/late meal; 4) Slept in; 5) Alcohol; 6) Other (please note reason)</th>
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<tbody>
<tr>
<td></td>
<td>1) Care giver/family</td>
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<td>2) EHS only</td>
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<td>3) Emergency Dept.</td>
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<td>4) Admission</td>
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## DKA

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<th>Date</th>
<th>Treated in Hospital</th>
<th>Treated in Emergency</th>
<th>What was the cause of the DKA (note number)? 1) Insulin omission; 2) Illness; 3) Pump/Pump site failure; 4) Insufficient monitoring; 5) Other (please note reason)</th>
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School/Daycare Plan in Place: [ ] Yes [ ] No [ ] NA

Dietitian Notes: ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Name (please print): ___________________________ Signature: __________________

Nurses Notes: ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Name (please print): ___________________________ Signature: __________________

Physician Notes: ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Name (please print): ___________________________ Signature: __________________