Addressograph Area

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

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

Breakfast	AM Snack	Lunch	PM Snack	Supper	Bedtime	2300	0300

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 ☐ Inset II® _____mm ☐ Comfort™ _____mm
☐ **Medtronic**: ..... ☐ Silhouette® _____mm ☐ Quick-Set® _____mm ☐ Mio® _____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 3-5days ☐ Every 5 or more days

---

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

Time	Rate	Time	Rate

Do you use temporary basal rates? ☐ Yes ☐ No

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

Insulin-to-Carb Ratios **Blood Glucose Targets**

Time	Ratio	Time	BG Target

CURRENT TOTAL DAILY DOSE (TDD): _____ **ISF**: _____ **ACTIVE INSULIN TIME**: _____ hours

---

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

DO NOT COMPLETE PAGE 4--To be Completed with Healthcare Providers

HYPOGLYCEMIA

Date	Treated by: 1) Care giver/family 2) EHS only 3) Emergency Dept. 4) Admission	Treated with glucagon (√)	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)

DKA

Date	Treated in Hospital	Treated in Emergency	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)

BP: _____ **Ht:** _____ **Wt:** _____ **Current A1C:** _____ **Last A1C:** _____ **A1C Goal:** _____

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: _____