Addressograph Area

PEDIATRIC ASSESSMENT - NEWLY DIAGNOSED

DIABETES CENTRE

Shading indicates optional completion when recorded elsewhere.
Use on **all newly diagnosed (ND)** new referrals.

Name: _____ Date: _____

Accompanied by: ❑ mother ❑ father ❑ sibs: _____ ❑ other: _____

Lives with: ❑ mother ❑ father ❑ other: _____

Information obtained from: ❑ mother ❑ father ❑ child ❑ other: _____

DEMOGRAPHIC INFORMATION

Mother: _____

Father: _____

Sibs (number, name, age): _____

_____

_____

Address: _____

_____

Province: _____

Postal Code: _____

Phone: Res: _____

Bus: (mother): _____

(father): _____

Occupation: (mother): _____

(father): _____

Other: _____

Relationship: _____

Address: _____

_____

Province: _____

Postal Code: _____

Phone: Res: _____

Bus: _____

Occupation: _____

Hours of work: _____

Hours of work: _____

Hours of work: _____

Drug plan: ❑ social assistance ❑ employment plan: _____

❑ other: _____ ❑ **none**

Pharmacy: _____ Phone: _____

Language spoken (if other than English): _____ Interpreter required: ❑ N ❑ Y

Religious, family, or cultural practices that may influence how child/family cares for health: _____

_____ ❑ **none**

School and grade: _____ Phone: _____

Signature: _____

Person completing demographic information (if other than RN/PDt)

Allergies (food, drug, environmental): ❑ N ❑ Y (note): _____

_____ ❑ **none**

DIABETES-RELATED INFORMATION

Age at onset: _____ **Date of diagnosis:** _____ Type of DM: ❑ type 1 ❑ type 2

Previous diabetes education: ❑ N ❑ Y (If yes, complete part 2 or Follow-up Assessment form)

When: _____

Where: _____

Present symptoms: ❑ ↑ thirst ❑ ↑ urination ❑ fatigue ❑ weight loss

❑ mood changes ❑ nausea/vomiting ❑ headaches ❑ blurred vision

❑ DKA (pH < 7.35) ❑ recent infections: _____

❑ other: _____

Describe illness at present: _____

_____

_____

_____ ❑ **none**

HEALTH STATUS

Medications (Non-DM – Include type/dose/frequency, OTCs, vit/min suppl): ❑ see Medication Sheet ❑ **none**

Medical problems: ❑ thyroid ❑ other (chronic illness/significant past illness/hospitalizations/disabilities):

_____

_____

_____

_____ ❑ **none**

Date of last immunization: _____ ❑ see attached card Other preventative measures: _____

How often do you see the following:

GP? _____ Name: _____

Specialist(s)? _____ Name: _____

_____ Name: _____

Dentist? _____ Name: _____

Eye Specialist? _____ Name: _____

Other? _____ Name: _____

❑ **INSTRUCTED (see Education Checklist)**

FAMILY HISTORY

Diabetes: ❑ mother ❑ father

❑ sibs: _____

❑ grandparents: (M): mother father

(P): mother father

❑ other: _____ ❑ **none**

How has it affected their lives? _____

CAD or PVD: ❑ N ❑ Y

Hypertension: ❑ N ❑ Y

Dyslipidemia: ❑ N ❑ Y

Thyroid disease: ❑ N ❑ Y

Other: _____

EXERCISE

Activities: _____

❑ **none**

Hobbies: _____

❑ **none**

❑ **INSTRUCTED (see Education checklist)**

NUTRITION *(for completion on newly diagnosed patients)*

Nutritional Status

Ht: _____ Wt: _____

Usual wt: _____

Recent wt change: _____

Applicable lab data (non diabetes): _____

Assessment

% wt loss: _____

Recent wt loss: ❑ not significant ❑ significant

❑ severe: _____

Interpretation of nutritional status: _____

Comments: _____

NUTRITION (cont)

Information obtained from: ❑ mother ❑ father ❑ child ❑ other: _____

Problems with: appetite: ❑ N ❑ Y _____

bowels: ❑ N ❑ Y _____

food intolerance/dislikes: ❑ N ❑ Y _____

_____

Eating response to stress/boredom: _____ ❑ **n/a**

Restaurant meals (frequency/food choices): _____

Others in family on special diet: ❑ N ❑ Y _____

Grocery shopping by: ❑ mother ❑ father ❑ other: _____

Food prepared by: ❑ mother ❑ father ❑ other: _____

Diet History (indicate usual meals/snacks per day and weekend variations)

Reflects: ❑ Usual intake ❑ 24-hour recall Attached: ❑ Food Record

Diet/special foods: ❑ sweetener Usual Intake: _____ Kcals/KJ

❑ diet drinks

NUTRITION (cont)

Problem Areas Based on Usual Intake ❑ **none**

❑ meal spacing ❑ meal irregularity ❑ inadequate snacks ❑ high fat

❑ poor meal balance ❑ variable CHO intake ❑ excessive calories ❑ high simple sugar

❑ inadequate fibre ❑ junk food

❑ nutritionally inadequate food group: ❑ milk ❑ fruit ❑ veg ❑ protein ❑ starch

❑ nutrition concerns at school: _____ ❑ **none**

❑ other: _____

_____

Comments/motivation: _____

_____

_____ ❑ **see page 5**

LOCAL USE

Optional: This page may be photocopied and sent as/with the report to the physician.

PROBLEM LIST – TEAM USE

❑ Diabetes education	❑ Adjustment to diagnosis:	❑ parents	❑ child	❑ sibs
❑ Fear of needles	❑ Family dysfunction		❑ School	
❑ Fear of checking blood	❑ Stress		❑ Financial	
❑ Eating problems	❑ Smoking		❑ _____	
❑ Inactivity	❑ Sexual health		❑ _____	
❑ Fear of hypoglycemia	❑ Driving practices		❑ _____	
❑ Severe hypoglycemia	❑ Behavioural		❑ _____	

COMMENTS

_____

_____

_____ ❑ **none**

NUTRITION RECOMMENDATIONS

_____

_____

_____ ❑ **none**

Signature: _____ Date: _____

NURSING RECOMMENDATIONS

_____

_____

_____ ❑ **none**

Signature: _____ Date: _____

OTHER RECOMMENDATIONS **Discipline:** _____

_____

_____

_____ ❑ **none**

Signature: _____ Date: _____

Non discipline-specific portions of this form were completed by the above: ❑ **RN** ❑ **PDt**

DC appointment for: ❑ 6 weeks ❑ 3 months ❑ 6 months ❑ other: _____

Referral to: ❑ social work: _____ ❑ community/home care: _____

❑ psychology: _____ ❑ ophthalmology: _____

❑ other: _____