Addressograph Area

PEDIATRIC ASSESSMENT
PART 2 - FOLLOW-UP

DIABETES CENTRE

Shading indicates optional completion when recorded elsewhere. Complete for known patient or NND new referral. Complete every 6-8 months for FU.

Name: _____

Date: _____

Duration of diabetes/Age at onset: _____

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

Lives with: ❑ mother ❑ father ❑ other: _____

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

Ht: _____	Change in ht: _____	%ile: _____	BMI: _____	Ht/Age: _____	
Wt: _____	Change in wt: _____	%ile: _____	IBW: _____	%IBW: _____	

Comments: _____

BP: _____ Pulse: _____ Glucose: Lab _____ Meter _____ *% difference _____

Staff Initials: _____ (*Meter to Lab comparison = M minus L, divided by L, multiplied by 100%)

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

_____ **❑ none**

INSULIN/OAA **❑ SYRINGE** **❑ PEN** **❑ PUMP** **❑ n/a**

	Meal Times						Comments
	Bkfst	a.m.	Lunch	p.m.	Supper	hs	(e.g., changes in activity, insulin adjustment, omits, takes when ill, skips meals, etc.)
Usual							
Weekend/Other							
Type of Insulin/OAA	Dosage						
							PUMP BASAL:
							_____ _____
							_____ _____

Total units: _____ *U/kg*: _____

BLOOD GLUCOSE MONITORING **❑n/a**

Method: _____ Frequency/day/week: _____

Time	% Results/category Based on ____days				Based on: ❑Record book ❑ Verbal report ❑Computer printout
	< 4 mmol/L	*4-10 mmol/L*	*> 10 mmol/L*	*Average*	Comments (e.g. weekend variations)
Bkfst					
Lunch					
Supper					
hs					

INSULIN

❑ **n/a**

Prepared by: ❑ mother ❑ father ❑ child ❑ other: _____

Supervised by: ❑ mother ❑ father ❑ other: _____

Injected by: ❑ mother ❑ father ❑ child ❑ other: _____

Appropriate technique: ❑ N ❑ Y ❑ not observed

Sites used: ❑ buttock R L ❑ leg R L ❑ arm R L

❑ abdomen R L ❑ calf (if applicable) R L

Appropriate site rotation: ❑ N ❑ Y

Lipodystrophy: ❑ N ❑ Y

Adjusts insulin: ❑ N ❑ Y

❑ **INSTRUCTED (see Education Checklist)**

BLOOD GLUCOSE MONITORING

❑ **n/a**

Tested by: ❑ mother ❑ father ❑ child ❑ other: _____

Recorded by: ❑ mother ❑ father ❑ child ❑ other: _____

Supervised by: ❑ mother ❑ father ❑ other: _____

Appropriate technique: ❑ N ❑ Y ❑ not observed

❑ **INSTRUCTED (see Education Checklist)**

HYPOGLYCEMIA

Symptoms: ❑ headache ❑ moody ❑ weak ❑ shaky ❑ hungry ❑ sweaty

❑ pallor ❑ nightmare ❑ other: _____ ❑ **none**

Are symptoms recognized by the child? ❑ N ❑ Y ❑ **n/a**

SEVERE* (date, type, frequency) Seizure? ❑ N ❑ Y _____

_____

_____ Treatment Appropriate? ❑ N ❑ Y

MODERATE (frequency, times) _____

_____ Treatment Appropriate? ❑ N ❑ Y

MILD (frequency, times) _____

Treatment Appropriate? ❑ N ❑ Y

*Severe hypoglycemia is defined as unable to help self.

HYPOGLYCEMIA (cont)

What treatment does the child/adolescent carry? _____

_____

Diabetes ID: ❑ N ❑ Y

Is school prepared to treat? ❑ N ❑ Y _____

Has teacher been given appropriate information? ❑ N ❑ Y _____

Glucagon at home: ❑ N ❑ Y Expiry date checked: ❑ N ❑ Y Prescription: ❑ N ❑ Y

❑ **INSTRUCTED (see Education Checklist)**

GENERAL HEALTH

Significant diagnoses: ❑ thyroid ❑ hyperlipidemia ❑ other: _____

❑ Vision problems: _____

❑ Menses onset: _____ frequency: _____ pain: _____ ❑ **n/a**

❑ Other: _____ ❑ **none**

Non diabetes medications (❑ see medication sheet): _____

_____

_____ ❑ **none**

Foot Care Practices (age ≥ 15 years): ❑ appropriate ❑ inappropriate

❑ **INSTRUCTED (see Education Checklist)**

SICK DAYS

Illness since last visit: ❑ N ❑ Y Number of days sick: _____

Describe: _____

_____

_____

Blood glucose problems when ill: ❑ N ❑ Y _____

_____

_____

Diabetes symptoms: ❑ polyuria ❑ nocturia (___/night) ❑ polydipsia ❑ enuresis ❑ headaches

_____

❑ Abdominal symptoms: _____

Ketones: Checked: ❑ N ❑ Y When: _____ By whom: _____

Testing: ❑ appropriate ❑ inappropriate ❑ never Expiry date checked: ❑ N ❑ Y

Action taken: ❑ appropriate ❑ inappropriate ❑ never

❑ **INSTRUCTED (see Education Checklist)**

EXERCISE

Activities: _____

_____ ❑ **none**

Hobbies: _____ ❑ **none**

Activity changes: _____

_____ ❑ **none**

Compensates appropriately for planned activity: ❑ N ❑ Y ❑ **n/a**

❑ snack

❑ insulin adjustment

❑ **INSTRUCTED (see Education Checklist)**

SOCIAL ASSESSMENT

Smoking: ❑ N ❑ Y Amount: _____ ❑ Willing to reduce/quit ❑ **n/a**

Social drugs: ❑ N ❑ Y Type/freq: _____ ❑ **n/a**

Alcohol: ❑ N ❑ Y Type/amount/freq: _____ ❑ **n/a**

Sexually active: ❑ N ❑ Y Birth control: _____ ❑ **n/a**

STD prevention: ❑ N ❑ Y _____ ❑ **n/a**

Driving: ❑ N ❑ Y Safe practices: ❑ N ❑ Y ❑ **n/a**

Grade in school: _____ Has made teacher/school aware of diabetes: ❑ N ❑ Y

Days missed from school since last visit: _____

School concerns/performance: _____

_____

_____

Family concerns/involvement: _____

_____

_____

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

_____

_____

Recent change in/of the family: _____

_____

_____

❑ **INSTRUCTED (see Education Checklist)**

LOCAL USE

NUTRITION--DIETITIAN ONLY *(for known patient or new referral if appropriate)*

CHO counting:	❑ N ❑ Y	
Present meal plan:	KJ/calories: _____	
Meal plan:	❑ appropriate ❑ inappropriate	
Meal/snack timing:	❑ appropriate ❑ inappropriate	
Treatment for hypoglycemia:	❑ appropriate ❑ inappropriate	
Compensation for activities:	❑ appropriate ❑ inappropriate	
School concerns:	❑ N ❑ Y	
Notable eating patterns:	❑ food restrictive behaviour	
	❑ overindulgence	
	Explain: _____	

Comments:

Meal plan /g CHO adjusted: ❑ N ❑ Y KJ/calories: _____ Pattern attached: ❑ N ❑ Y

___ g breakfast; ___ g a.m. snack; ___ g lunch; ___ g p.m. snack; ___ g supper; ___ g hs snack

❑ **INSTRUCTED (see Education Checklist)**

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: _____