Addressograph Area

# INSULIN PUMP FOLLOW-UP FORM

**NAME:** ______________________________

**DATE:** ______________________________

To help us make the most of your visit, please take a few minutes to complete this form. This will help us focus on areas of greatest interest to you.

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

______________________________________________________________________

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

- ☐ Diet
- ☐ 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
- ☐ Other ______________________________

**Have you/your child made any changes to basal rates, insulin-to-carbohydrate ratios, and/or correction factor (ISF) since your last visit? If so, please explain:**

☐ Basal Rates ______________________________

______________________________

☐ Insulin-to-Carb Ratio ______________________________

______________________________

☐ Correction Factor (ISF) ______________________________

______________________________

## SELF-MONITORING OF BLOOD GLUCOSE (SMBG)

Glucose Monitor Type: ______________________________

How often do you check blood glucose? ______________________________

Are blood glucose records kept? ☐ Yes ☐ No

If yes, how often do you review blood glucose records? ______________________________

What are the average blood glucose values for the last 14 days?

| Breakfast | AM Snack | Lunch | PM Snack | Supper | Bedtime | 2300 | 0300 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## HYPOGLYCEMIA (LOW BLOOD GLUCOSE)

Have any blood glucose values been less than 4 mmol/L…

…in the past 7 days? ☐ Yes ☐ No

…in the past month? ☐ Yes ☐ No

If you answered yes to either question, how many times? ______________________________

What causes the lows? ______________________________

Did you/your child need help to treat the low? ☐ Yes ☐ No

Did any lows happen overnight? ☐ Yes ☐ No

If yes, what caused the overnight lows: ☐ Illness ☐ Exercise ☐ Insulin Dose Error ☐ Don't know ☐ Other ______________

## ACTIVITY

You/your child exercise(s). ☐ Yes ☐ No

If yes, what types of exercise/activity? ______________________________

______________________________

Are adjustments made to insulin/food for exercise(s)? ☐ Yes ☐ No

Please explain how you/your child adjust(s) for activity. ______________________________

______________________________

______________________________

## GOALS

What are your/your child's goals in diabetes management for the next month?

______________________________

______________________________

______________________________

______________________________

## INSULIN PUMP

Insulin Pump Type: ☐ Animas ☐ Medtronic ☐ Omnipod

Pump Start Date: ____________________

**BASAL INSULIN**: ☐ Humalog® ☐ NovoRapid® ☐ Apidra®

**BASAL PROFILE:**

| Time | Rate | Time | Rate |
|---|---|---|---|
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| | | | |
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**NOTE**: **The above may also be downloaded from the insulin pump**.

**BOLUS**:

Insulin Sensitivity Factor (ISF): __________

Insulin-to-Carbohydrate Ratios: ____________________

____________________

Infusion set type: ____________________

Your insert sites are: ☐ Abdomen ☐ Hip ☐ Thigh ☐ Arm

How often is the insertion site changed? ____________________

Have you had a pump failure or ketones lately? ☐ Yes ☐ No

If yes, how did you manage this? ____________________

Based on your records, how would you determine whether to make a basal/bolus change?

____________________

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## TO BE COMPLETED BY THE DIABETES HEALTH CARE TEAM

*Written contributions to this plan by persons other than those indicated at the bottom of this page should be signed.*

### Diabetes Team Notes:

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### Plan:

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| Date | Name (Print) | Signature | Initials | Discipline |
|---|---|---|---|---|
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**Nondiscipline-specific portions of the initial assessment form were completed by**: ❑ PDt ❑ RN ❑ Other ____________