Children's Hospital and Health System™ | Medical College of Wisconsin

Children's Specialty Group™

Child's name:_____

Date of Birth:_____

Date of Visit:_____

Check up clinic visits

Families to Bring to Clinic Completed.

Please complete the following information about your blood sugar levels and your pump settings

14 day Blood Sugar Averages:

*****Please remember to also bring your logbook and blood sugar meter with you*****

Breakfast	Snack	Lunch	Snack	Dinner	Snack	Night	Night

Basal Rates:

Start time		
	1. 12 MN	_____u/hr
	2. _____	_____u/hr
	3. _____	_____u/hr
	4. _____	_____u/hr
	5. _____	_____u/hr
	6. _____	_____u/hr
	7. _____	_____u/hr

Total Daily Basal from pump:

_____units

Insulin to carb ratios:

Start time		
	1. 12 MN	_____grams
	2. _____	_____grams
	3. _____	_____grams
	4. _____	_____grams
	5. _____	_____grams

Daily Totals from Pump (Last 7 days):

1. _____units
2. _____units
3. _____units
4. _____units
5. _____units
6. _____units
7. _____units

Average: _____units

Correction/Sensitivity:

Start time		
	1.12 MN	1 unit per _____mg/dl
	2. _____	1 unit per _____mg/dl
	3. _____	1 unit per _____mg/dl

BG targets/target range settings:

Start time			(Animas pumps)	(Omnipod Pumps)
	1. 12 MN	_____mg/dl	+/- _____	_____(_____)
	2. _____	_____mg/dl	+/- _____	_____(_____)
	3. _____	_____mg/dl	+/- _____	_____(_____)

Insulin Time Action/Insulin-On-Board Duration: _____hr.

Please Turn Over

Your questions/concerns today:

_____

_____

Is there anything you feel needs improvement in your diabetes management?

_____

_____

Since your last visit have there been changes in your child's health history?
(Please list any illnesses, injuries, hospitalizations, severe low blood sugars, DKA episodes, etc.)

Event	Date	Event	Date
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Do you need Prescriptions refilled at this visit? YES / NO

- ☐ Walk in Pharmacy- 30 day supply with 1 year refill
- ☐ Mail Order Prescription – 90 day supply with 1 year refill

Name of Pharmacy: _____ **Address/Location**:_____

Please list current *Diabetes* medications and supplies:

- ☐ Humalog (KwikPen) // (Luxura HD Cartridge) // (Vial)
- ☐ Novolog (FlexPen) // (NovoPen Jr. Cartridge) // (Vial)
- ☐ Lantus (Solostar Pen) // (Vial)
- ☐ Levemir (FlexPen) // (Vial)

- ☐ Syringes (type)_____length_____
- ☐ Pen needles (type)_____length_____
- ☐ Strips for meter (type)_____
- ☐ Lancets (type)_____

- ☐ Ketone Strips
- ☐ Glucagon

*****Prescriptions are generally written with 1 year of refills. We prefer to give you prescriptions while you are here. Due to the volume of patients we service, there may be a delay in renewing your prescriptions over the phone.*****

Please let us know of any support systems or support groups you have to help with your diabetes self management:
(Examples include: Read diabetes magazine, attend support group, have grandparents help with cares, etc.)

_____

_____

(Please note: This section is included as information for the diabetes clinic to help us better serve you. It is a part of programs that are recognized by the American Diabetes Association)

Coping:

- ☐ Do you have trouble with injections or finger pokes? If so what?
  - ☐ Leaking ☐ Lumps ☐ Fear of shots/pokes ☐ Missing shots/pokes
- ☐ Do you have trouble sleeping?
- ☐ Do you have trouble working together as a family?
- ☐ Other issues with coping_____

Do you need other forms today?

- ☐ School Health Plan or other form signed
- ☐ Family Medical Leave Papers signed
- ☐ Travel letter/Prescription/Information
- ☐ Camp form signed
- ☐ Other_____