Pediatric Endocrine Society Kenya

PAEDIATRIC & ADOLESCENT DIABETES REVIEW FORM

HOW DO YOU REVIEW A PATIENT WITH DIABETES?

Review of patients with diabetes in primary care

1. Current health, medication and compliance.
2. History of hypoglycemic and hyperglycemic episodes.
3. Blood or urine testing diary.
4. BP, pulse weight, height and BMI
5. Visual acuity and feet.
6. Blood glucose and 3-monthly HbA1c.
7. Patient concerns.

GENERAL INFORMATION:

Name:_____ Date of Birth:_____ Age:_____ Gender:_____ OP/IP No:_____ Tel No:_____

Email:_____ Insurance (specify):_____ Referred by:_____

Employment status of: Father/Guardian_____ Mother/Guardian_____

Date of Diagnosis:_____/_____/_____ Diabetes Type: □Type 1 □ Type 2 □ Other (specify)_____

Allergies:_____

BASELINE LAB TESTS:

HbA1c_____ date_____ Renal Panel_____ date_____ Thyroid Profile_____mm_____ date_____
Thyroid Antibodies _____ Lipid Profile_____ date_____ Full Blood Count_____
GAD-65 Abs_____date_____ Islet cell Abs _____date _____ Insulin Abs_____ date_____ ZnT8 Abs_____ date_____
Celiac antibodies _____date _____ Other _____

FAMILY HISTORY: Indicate relationship to patient (blood relatives) (M, F, S, MGM, PGF, etc.)

Type 1 diabetes_____ Thyroid disease_____ Adrenal disease_____ Celiac disease_____
Type 2 diabetes_____ Celiac disease_____ Rheumatoid Arthritis_____ Other_____

PATIENT CONCERNS:

Today's Date: _____ Old/ New Patient: _____ Diabetes Duration _____

Current Weight (kg)_____percentile/SD_____ Height (cm)_____percentile/SD_____ Mother's Height (cm)_____ Father's Height (cm) _____

Target Height (cm) _____ BMI (≥2yr)_____percentile/SD_____ Head circumference (<3 yr) (cm)_____percentile/SD_____

W/H (<2yr) percentile/SD_____ BP_____percentile_____ Pulse Rate_____ RR: _____ SPO2_____ RBS _____Time _____

Last menstrual period:

Complaints/ Symptoms:

DIABETES EDUCATION:

Has patient previously received education on:

Insulin therapy? □ NO □ YES

Management of hyperglycemia? □ NO □ YES

Management of hypoglycemia? □ NO □ YES

Carbohydrate counting? □ NO □ YES

Diabetes and exercise? □ NO □ YES

Pediatric Endocrine Society Kenya

PAEDIATRIC & ADOLESCENT DIABETES REVIEW FORM

INSULIN THERAPY:

NORMAL INSULIN DOSES					
Insulin type/brand	Breakfast Dose	Lunch Dose	Dinner Dose	Bedtime	Night/Other
	units	units	units	units	units
	units	units	units	units	units
Insulin: Carb Ration	1 unit:_____grams	1 unit:_____grams	1 unit:_____grams		

Total Daily Dose of insulin _____ Insulin Basal: Bolus Ratio _____ Insulin dose/kg _____

Mode of insulin delivery ☐ Syringe/ Needle ☐ Insulin Pen ☐ Continuous Subcutaneous Insulin Infusion (Insulin pump)

What sites are been used? ☐ Abdomen ☐ Buttocks ☐ Thighs ☐ Arms Any problems with sites? ☐ NO ☐ YES

Site problems ☐ Lipoatrophy ☐ Lipohypertrophy ☐ Abscess ☐ Other (specify) _____

How many doses missed per week?_____Reason_____

Injections: Who draws up?_____Who injects?_____If patient, who oversees? _____

Correction factor: _____How many times hyperglycemia corrected/week?_____

BLOOD GLUCOSE MONITORING & CONTROL:

Meter(s) used:_____ Did patient bring all of them today? ☐ NO ☐ YES

Blood glucose is usually checked_____times a_____ BG checks after bedtime ☐ NO ☐ YES ☐ Sometimes

Blood glucose checked by ☐ Patient ☐ Parent ☐ Other_____ If by patient, who oversees? _____

Target range for BG levels? Pre-meal_____ to _____ Post-meal_____ to _____ Do meter readings reflect recorded readings? ☐ YES ☐ NO

BG time in range (Target 70%) Fasting _____ 2hr post-breakfast_____ Pre-lunch_____ 2hr post-lunch ___

Pre-dinner_____ 2hr post-dinner_____ Hypoglycemia (Target <4%) _____

Time above range (Target <25%) _____

Since last visit, is control? ☐ Same ☐ Better ☐ Worse Reason for change? _____

HIGH BLOOD GLUCOSE Since last visit:

Symptoms of high BG? ☐ NO ☐ YES (Circle) - thirst, polyuria/nocturia, hunger, tiredness. Other_____

Possible causes for high BG?_____ Has patient had ketones? ☐ NO ☐ YES

Corrective actions taken _____ Do they help? ☐ NO ☐ YES ☐ SOME

LOW BLOOD GLUCOSE Since last visit:

Symptoms of low BG? ☐ NO ☐ YES (Circle) - shakiness, sweating, dizziness, hunger. Other_____

At what BG level do warnings begin?_____ Can patient recognize them? ☐ Always ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

Possible causes of low BG?_____ Corrective actions taken_____

NUTRITION/MEAL PLAN:

What approaches are used? ☐ Carb-counting (grams/choices) ☐ Other (specify)_____

If carb-counting, please complete grid below.

	Breakfast	Mid a.m.	Lunch	Mid aftn	Dinner	Bedtime
Time						
Carb Target/Actual	/	/	/	/	/	/

EXERCISE/ACTIVITY: Please note normal activity on grid below.

	Early a.m.	Late a.m.	Early aftn	Late aftn	Evening	Other
Activity						
Days						

Pediatric Endocrine Society Kenya

PAEDIATRIC & ADOLESCENT DIABETES REVIEW FORM

HEALTH MAINTENANCE:

Date of last dental check-up:_____ Date of last eye exam:_____ Does patient smoke? □ NO □ YES Does patient take alcohol? □ NO □ YES

Immunizations (date): Pneumococcal_____ Meningococcal_____ Influenza_____ Tetanus_____ Other _____

Labs: HbA1c_____ date _____ Urine Albumin Creatinine Ratio_____ date_____ Creatinine_____ date_____

Thyroid_____ date_____ Cholesterol_____ date_____ GAD-65 Abs_____date _____ Islet cell Abs _____date _____

Insulin Abs_____ date_____ ZnT8 Abs _____ Celiac antibodies_____ date_____Other_____

DIABETES-RELATED HEALTH EVENT: Since last visit when diabetes was at least part of the reason

Hospital stay: □ NO □ YES_____ Emergency Room Visits, not admitted: □ NO □ YES _____

Emergency Calls to 911/Health Care Provider: □ NO □ YES Were any of these events related to hypoglycemia? □ NO □ YES

FAMILY HISTORY: Indicate relationship to patient (blood relatives) (M, F, S, MGM, PGF, etc.)

Type 1 diabetes_____ Thyroid disease_____ Adrenal disease_____ Celiac disease_____

Type 2 diabetes_____ Celiac disease_____ Rheumatoid Arthritis_____ Other_____

SOCIAL HISTORY UPDATE:

Who does the patient currently live with?_____ Email address/telephone contact:_____

If living with parent(s), patient lives with □ both parents □ single parent since (date)_____ If parents are separated, since when? _____

Has patient moved since last visit? □ NO □YES

Who in home helps with diabetes care?_____ Has this changed recently? □ NO □ YES

Grade in School:_____ Last school change?_____(mo/yr) School absences in last 12 months:_____days

How is patient doing in school?_____ Is the school involved in the diabetes management? □ NO □YES

Chronic stressors: □ Family relations □ Peer Relations □ School □ Financial worries □ Coping with Diabetes

EXAMINATION:

General:

Skin: Dental:

Neck: Joints:

Injection sites: Respiratory:

Cardiovascular: Nervous:

Abdomen: Genitourinary:

Puberty (tanner stage): PH B/G Testicular volume: Right Left

Foot exam: Left Right

PAEDIATRIC & ADOLESCENT DIABETES REVIEW FORM

TYPE 1 DIABETES CHRONIC CARE MAINTENANCE:

ANNUAL SCREENING Year_____

ASSESSMENT	DATE OF EXAM	RESULTS	COMMENTS/ ACTION
Psychosocial screening			
Foot examination			
Dental examination			
Dilated eye exam			
Thyroid function test			
Urine albumin creatinine ratio			

VISITS

ASSESSMENT	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Blood pressure												
BMI												
Weight (kg)												
Height (cm)												
Blood glucose Time in Range (%)												
Blood glucose Time Above Range (%)												
Blood glucose Time Below Range (%)												
Injection site assessment												
Smoking cessation counselling												
New self-management goal (Yes/No)												
Next planned visit:												

PLAN:

Medication changes:_____

Investigations:_____

Referrals: ☐ Diabetes education ☐ Nutrition ☐ Ophthalmology ☐ Psychotherapy ☐ Group visit ☐ Other_____

Immunizations: ☐ Pneumococcal ☐ Meningococcal ☐ Influenza ☐ Tetanus ☐ Other _____

New self-management goal:

HEALTH CARE PROVIDER NAME: _____ **SIGN**: _____ DATE:_____

Prepared by Amolo P, Mungai L, Maigua J, Wamalwa P, Lusweti B