nova scotia health authority | Diabetes Care Program of Nova Scotia

Pediatric to Adult Diabetes Centre
Transition Summary

Diabetes Centre (DC)

To be completed by the Diabetes Team and forwarded to the receiving DC, Endocrinologist/Internist, and the Family Physician.

DATE OF DIAGNOSIS: _____ **AGE AT ONSET:** _____

TO: _____ _____
Physician Physician Appointment Date

_____ _____
Diabetes Centre (DC) DC Appointment Date

_____
Adult Designate Name (DC team member appointed to coordinate integration to adult DC)

E-mail: _____ Phone: _____

CONTACT INFORMATION ☐ **as above addressograph**

New address: _____ ☐ No address yet

Phone: _____
Home Cell Work

E-Mail: _____

Next of Kin: _____ Relationship: _____

Address: _____ E-mail: _____

Phone: _____
Home Cell Work

SUMMARY OF ATTACHMENTS

- ☐ Pediatrician Referral Letter
- ☐ Diabetes Educator Transition Checklist
- ☐ Pediatric Flow Chart (includes lab tests)
- ☐ Growth Chart
- ☐ Most recent Meal Plan
- ☐ Other: _____

Date of last pediatric visit/contact: _____

REFERRAL SENT TO:

- ☐ Endocrinologist/Internist
- ☐ Adult Diabetes Centre (DC)
- ☐ Specialist/DC contacted in advance of referral

Name: _____

COPY OF REFERRAL SENT TO:

- ☐ Family Physician

Name: _____

- ☐ Other: _____

DIABETES-RELATED INFORMATION

INSULIN/OAA ☐ SYRINGE ☐ PEN ☐ PUMP ☐ **N/A**

Pump Model/Type: _____ Pump Start Date: _____

Warranty Expiry Date: _____ Calculator (wizard) used: ☐ No ☐ Yes

Off Pump Plan: ☐ No ☐ Yes Basal Insulin doses for off Pump, if required: ☐ No ☐ Yes ☐ **N/A**

Continuous glucose monitoring system (CGMS): ☐ No ☐ Yes

Insulin/OAA	Meal Times						Comments (e.g., changes in activity, insulin adjustment, omits, takes when ill, skips meals, etc.)
	Bkfst		Lunch		Supper	HS	
Usual							
Weekend/Other							

Type of Insulin/OAA	Dosage						Pump Basal Rates
							12:00 a.m.
							24 hr Basal: _____ TDD: _____

Total units: _____ *u/kg:* _____

Insulin/Carb Ratio: Bkfst _____ Lunch _____ Supper _____ HS _____ Snacks _____

ISF/Correction Factor: _____ Insulin on Board (IOB): _____

Blood Glucose Target: _____ (day) _____ (hs/overnight)

Comments: _____

_____

_____

_____ ☐ **No immediate concerns**

DKA (Episodes within last 2-4 years, excluding diagnosis):

☐ Never ☐ (1-2) ☐ (3-4) ☐ (>4) Date of last DKA: _____

Comments: _____

_____

_____ ☐ **No immediate concerns**

HYPOGLYCEMIA (Problematic episodes within last 2-4 years):

Moderate: ☐ Never ☐ (1-2) ☐ (3-4) ☐ (> 4)

Severe: ☐ Never ☐ (1-2) ☐ (3-4) ☐ (> 4) Date of last episode: _____

Hypoglycemia Unawareness: ☐ No ☐ Yes Medic Alert/ID: ☐ No ☐ Yes

Comments: _____

_____

_____ ☐ **No immediate concerns**

HEALTH STATUS

Allergies (food; drug; environmental): ☐ No ☐ Yes (note): _____

_____ ☐ None

Other Medical Conditions: _____

_____

_____ ☐ None

Other Medications: ☐ No ☐ Yes Home Pharmacy: _____

Name	Dose	Route	Time

Other Specialists/Health Care Providers

☐ Ophthalmologist Name: _____ ☐ **n/a**

☐ Nephrologist Name: _____ ☐ **n/a**

☐ Gastroenterologist Name: _____ ☐ **n/a**

☐ Psychologist/Psychiatrist Name: _____ ☐ **n/a**

☐ Eating Disorder Clinic Name: _____ ☐ **n/a**

☐ Other Name: _____ ☐ **n/a**

Comments: _____

_____

_____ ☐ **No immediate concerns**

NUTRITION

Current Wt: _____ (Kg/lbs) Height: _____ (cm) BMI: _____

Present meal plan: _____ CHO Counting: ☐ No ☐ Yes

Diet restrictions/special diet: ☐ No ☐ Yes (describe) _____

Challenging eating patterns: ☐ No ☐ Yes (describe) _____

☐ **No immediate concerns**

PHYSICAL ACTIVITY/EXERCISE

☐ Very active ☐ Moderately active ☐ Sedentary

☐ Organized activities: _____ Frequency: _____

☐ Gym/Fitness Centre: _____ Frequency: _____

☐ Other: _____ Frequency: _____

Comments: _____

Compensates appropriately for planned activity: ☐ No ☐ Yes

If yes, how? ☐ **Snack** ☐ **Insulin adjustment** (☐ MDI ☐ Pump) ☐ **Both**

Describe specific adjustments: _____

☐ **No immediate concerns**

PSYCHOSOCIAL

Current Living Arrangement: ☐ Parent/Guardian ☐ Sibling(s) ☐ Lives alone ☐ Roommate
☐ Insecurely housed (e.g., shelters) ☐ Other: _____

Anticipated change to living arrangement: _____

Family relationships/Dynamics/Key support persons (describe): _____

PSYCHOSOCIAL (cont)

Smoking: ☐ Current ☐ Past Freq.: _____ ☐ Never Type/Amount: _____

Alcohol use: ☐ Current ☐ Past Freq.: _____ ☐ Never Type/Amount: _____

Drug use: ☐ Current ☐ Past Freq.: _____ ☐ Never Type/Amount: _____

Mental Health Concerns: ☐ No ☐ Yes (describe) _____

Comments: _____

_____

_____ ☐ **No immediate concerns**

EDUCATION/EMPLOYMENT

At time of Transition:

☐ High School
☐ University/College Program
☐ Job (☐ full-time ☐ part-time)
☐ Other: _____

Future Plans:

☐ Further Study
☐ Work
☐ Unknown

Comments: _____

_____

_____ ☐ **No immediate concerns**

MEDICAL/INSURANCE COVERAGE

☐ **No Coverage**

☐ Private Plan (☐ Student ☐ Parent ☐ Employment)
☐ Family Pharmacare
☐ Community Services Pharmacare ☐ Other: _____

AUTONOMY/SELF-MANAGEMENT

Demonstrated knowledge level/skill for effective diabetes self-management:

☐ Needs Work ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Demonstrated motivation for effective diabetes self-management:

☐ Needs Work ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

ATTENDANCE AT CLINICS

☐ Routinely attends appointments ☐ Notifies clinic of cancellation ☐ Needs reminders

SIGNIFICANT AREAS OF CONCERN (ADDITIONAL INFORMATION ON PREVIOUS PAGES)

☐ **DKA**: ☐ Recurrent ☐ **Hypoglycemia**: ☐ Frequent ☐ Severe Hypoglycemia

☐ **Insulin Management**: ☐ Insulin adjustment ☐ Insulin omission ☐ Insulin manipulation
☐ Lipodystrophy ☐ Problem-solving ☐ Other: _____

☐ **Insulin Pump Management**: ☐ Overall knowledge/skill ☐ Basic features
☐ Advanced features ☐ Other: _____

☐ **Poor Glycemic Control**: A1C ranges: _____ Most recent A1C: _____

☐ **Illness Management**: ☐ Problem-solving ☐ Other: _____

☐ **SMBG**: ☐ Frequency/times ☐ Use of information ☐ Record keeping

☐ **CGM/FGM**: ☐ Frequency/times ☐ Use of information ☐ Record keeping

☐ **Nutrition**: ☐ Meal balance ☐ Meal irregularity ☐ Disordered eating
☐ Other: _____

☐ **Psychosocial Issues**: ☐ Mental health concerns ☐ Family relationships
☐ Alcohol ☐ Drug use ☐ Smoking ☐ Other: _____

☐ **Complications**: _____

☐ **Other**: _____ ☐ **None**

☐ **REFERRAL TO TRANSITION CONSULTANT** **DATE:** _____

COMMENTS:

_____

_____

_____

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____
Pediatric Designate Name (Pediatric team member appointed to coordinate transition to adult DC)

E-mail: _____ **Phone:** _____