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GUIDE TO TRANSITION SUMMARY FORM

March 2019

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) ____________ Diabetes Centre 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: ____________

OBJECTIVES

- To ensure the transfer of all pertinent information as adolescents transition from pediatric to adult diabetes care. This includes contact information, diabetes-related information, health status, psychosocial issues, future education/employment plans, diabetes knowledge/skill development, and ability to self-manage this chronic disease.
- To highlight any noted knowledge and skill deficits and identified areas of concern.
- To provide preview/background information on the transferring adolescent prior to his/her first clinic/physician visit.
- To provide a user-friendly format for recording the above data.
- To facilitate the participation of all pediatric team members in the completion of this form.

GUIDELINES

- This form is to be completed on all adolescents transitioning from pediatric to adult diabetes care.
- A copy of this form is to be forwarded to each of the following:
  1. **Adult Diabetes Centre (DC)**
  2. **Endocrinologist/Internist**
  3. **Family Physician**
- The **"Pediatric Designate**" (Case Manager) is responsible for ensuring the completion and forwarding of this form and copies of additional attachments as listed on page 1 of the Transition Summary form.
- The form may be completed in any order. Input from **all** members of the Pediatric Diabetes Care Team is encouraged.
- If any discipline is uncomfortable with any section or portion of a section, a decision should be made locally as to who should complete that portion of the form.

USING THIS GUIDE

- The Transition Summary form has been designed in keeping with the DCPNS Pediatric Initial Assessment and Follow Up forms. Therefore, the layout and flow will be familiar to many educators.
- This guide is to be used in conjunction with the DCPNS pediatric to adult DC Transition Summary form. **As you read through this guide, refer to the corresponding sections of the Transition Summary form.**
- Only items that require explanation, based on feedback from educators, are outlined in this guide.
- Completion of the ❑ **No immediate concerns** box, even when an entry has been made in the comment section, allows the adult team to quickly identify those areas where the adolescent is doing well. Focus can then be directed to areas that require urgent attention.

GENERAL INFORMATION

ADDRESSOGRAPH

- Label this space with complete, accurate, and legible identifiers.
- Addressograph or print information.
- Record date of diagnosis.

PHYSICIAN / DIABETES CENTRE

- Provide the name of the Endocrinologist/Internist who will be caring for the adolescent in the adult setting.
- Provide the name of the adult DC the transitioning adolescent will be attending.
- Provide the name and contact information for the "Adult Designate."

SCHEDULED APPOINTMENT DATE

- The appointment dates that have been **pre-arranged** by the pediatric team in consultation with the adult diabetes team and the adolescent.
- This is the date of the adolescent's first official (transition) visit to the receiving Endocrinologist/Internist and to the adult DC.
- These appointments may or may not be scheduled for the same day.
- **The adolescent should be given an appointment card with these dates during the last visit at the pediatric centre**.

CONTACT INFORMATION

- Record the address where the adult team will be able to contact the adolescent.
- Include the phone numbers: home, cell, and work (if applicable) and e-mail address.
- Record next of kin contact information. Specify their relationship to the adolescent.
- This information may be required in the event of an emergency or lost contact with the adolescent.

SUMMARY OF ATTACHMENTS

- Indicate all attachments that are being forwarded with this Transition Summary form.
- The receiving Endocrinologist/Internist and DC can refer to this list to make sure they have received all of the forwarded attachments.
- Use the "other" space to identify any additional attachments that you intend to forward.
- If the Pediatrician participates in the completion of this form, he/she may choose not to attach a referral letter.
- Record the date of the last pediatric visit.

REFERRAL SENT TO

- Indicate where the referral and Transition Summary form is being sent (i.e., Endocrinologist/Internist, specialist, adult DC etc.). Ensuring all the adult team members have received the same information will avoid the need for the adolescent to "re-tell" his/her story several times to different team members. It will also enhance the continued "team" approach in adult care.
- If contact was made with an adult team member in advance of the referral, record the name of the person contacted.

DIABETES RELATED INFORMATION

INSULIN / OAA

- Record the type/name of the adolescent's **current** insulin and/or OAA (include dosing schedule, TDD, and u/kg, where applicable).
- Indicate method of insulin delivery (syringe, pen, or pump).
- If using an insulin pump, record pertinent information (include pump type, start date, basal rates, etc.).
- If the adolescent has been provided with an off-pump plan, record and send a copy along with insulin doses.
- Record if uses continuous glucose monitoring.
- Record insulin-to-CHO ratios, insulin sensitivity/correction factor, insulin on board (IOB), and blood glucose targets.
- Use the comment section to elaborate on any specific issues or concerns regarding the adolescent's experiences with insulin-to-CHO ratios, correction factor, pumps, CGMS, insertion/injection sites, achieving blood glucose targets, adjusting for changes in activity and sick days, skipping meals, etc.
- **Check ☑ if *No immediate concerns*.**

DKA / HYPOGLYCEMIA

- Record date and frequency of **problematic** episodes of DKA and hypoglycemia and date of last episode of either.
- Add comments on reasons for these episodes, interventions/action taken, education approaches, etc.
- Record hypoglycemia unawareness, if applicable.
- **Check ☑ if *No immediate concerns***

HEALTH STATUS

Other Medical Conditions

- Record any **ALLERGIES** (food, drugs, environmental).
- Indicate type and duration of any additional medical conditions.
- Use the comment section to identify any significant past illness, hospitalizations, and disabilities.
- **Check ☑ if *No immediate concerns.***

Other Medications

- Record only **non-diabetes medications** (include type, dose, and frequency), including OTCs, vitamins, and minerals.
- **If no additional medications check ☑ *None*.**
- Record name and phone number of the adolescent's home pharmacy.

Other Specialists/Health Care Providers

- Record name of any additional specialists or health care providers seen by the adolescent.
- Use the comment section to elaborate on any specific issues or concerns.
- **Check ☑ if *No immediate concerns.***

NUTRITION

- This section is to be completed by the dietitian.
- Record current weight, height, and BMI and indicate if CHO counting.
- Identify and use the space provided to describe any special diets and/or restrictions.
- Indicate and use the space provided to describe any problematic eating patterns or other information related to comprehension, matching food to insulin, etc.
- **Check ☑ if *No immediate concerns.***

PHYSICAL ACTIVITY AND SPORTS

- Record level of activity as indicated as well as the type and frequency of physical activity/exercise.
- Use the comment section to provide additional information (include preferred type and frequency of activity as well as any identified past/present barriers to engaging in regular physical activity).
- Indicate if adolescent compensates appropriately for planned activity. If yes, indicate how (snack, insulin adjustment, or both).
- Use the comment section to describe the adolescent's experiences (either positive or negative) in managing blood glucose before, during, and after physical activity/sports.
- **Check ☑ if *No immediate concerns.***

PSYCHOSOCIAL

- Identify current living arrangement. This will provide information re: the adolescent's family/social supports at the time of transition.
- Under "other" record living arrangement issues and identify any additional person(s) living in the home.
- Indicate any anticipated change to living arrangement. Will plans involve moving away from home and living alone or with a roommate? Who will then provide support?
- Under Family Relationships/Dynamics/Supports, provide the adult team with a "snapshot" of the adolescent's interaction with family/support systems. Note any positive or negative influences that may impact the adolescent's diabetes management, safety, etc.
- Complete the lifestyle section on smoking, alcohol/drug use, and any mental health concerns.
- Use the comment section to expand on any problematic lifestyle issues. Describe approaches taken, education provided, adolescent responses, and outcomes. Identify any additional or ongoing concerns.
- **Check ☑ if *No immediate concerns.***

EDUCATION / EMPLOYMENT

- Indicate what the adolescent is actually doing at the time of transition (at the time this summary form is being filled out). Is he/she attending high school, university/college, working at a full or part-time job, etc.
- Indicate plans for the future - those "talked about" plans for education, getting a job (locally or away), traveling, etc. **If the adolescent has no idea what he/she will be doing in the near future, check ☑ Unknown.**
- The "other" section may be used to describe options not listed above such as "attending Trade School," "joining the military," or "plans are on hold as presently caring for ill relative," etc.
- **Check ☑ if *No immediate concerns.***

MEDICAL / INSURANCE COVERAGE

- Indicate any medical plan or insurance coverage. It is important for the adult diabetes team to know if the adolescent will have the financial resources required to purchase diabetes medications and supplies.
- Use the "other " section to describe alternative financial coverage or to elaborate on an existing plan.
- **Check ☑ if *No Coverage.***

AUTONOMY / SELF MANAGEMENT

- This section provides the adult diabetes team with the **pediatric team's assessment** of the adolescent's ability and motivation to self-manage his/her diabetes at the time of transition. This information reflects the team's experiences/ interactions with the adolescent and their observations of how he/she applies acquired knowledge and skills (including goal-setting and problem solving) to effectively manage his/her diabetes.

ATTENDANCE AT CLINICS

- Indicate the adolescent's most likely behaviour based on past practice. Is he/she likely to attend clinic appointments or more likely to be a "No Show." This information alerts the "Adult Designate" (and team) to immediately implement strategies designed to prevent these indentified individuals from being "lost to follow-up care" during transition.

SIGNIFICANT AREAS CONCERNS

- All members of the pediatric team should participate in completing this section.
- Indicate any key areas of concern regarding diabetes management and that require further/ongoing education/skill development. Additional information on any areas checked would be found in the specific section or could be included in the comments section.
- Outline any special attributes/qualities and/or any identified or potential problems/concerns.

REFERRAL TO TRANSITION CONSULTANT

- Indicate if a referral has been made to the Transition Consultant and the date the referral was made.

SIGNATURES / DATES / PEDIATRIC DESIGNATE

- Signatures are required from each pediatric team member providing documentation on this form along with the date of completion.
- Complete the name and contact information of the "Pediatric Designate" in case there is a need for the adult team to contact this individual.