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?

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

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?

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>AM Snack</th>
<th>Lunch</th>
<th>PM Snack</th>
<th>Supper</th>
<th>Bedtime</th>
<th>2300</th>
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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:**

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<th>Time</th>
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NOTE: The above may also be downloaded from the insulin pump.

**BOLUS:**

Insulin Sensitivity Factor (ISF): ____________

Insulin-to-Carbohydrate Ratios: ________________________________

In 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?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
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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<th>Discipline</th>
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Nondiscipline-specific portions of the initial assessment form were completed by:  
  PDt  RN  Other  