Children's Hospital and Health System™
Children's Specialty Group™
MEDICAL COLLEGE OF WISCONSIN

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 u/hr

1._____ 12 MN - _____

2._____

3._____

4._____

5._____

6._____

7._____

Total Daily Basal from Pump: _____ units

Daily Totals from Pump (Last 7 days):

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	7 Day Avg.

ICR (Insulin/carb Ratio):

Break: _____ unit(s) per _____ grams of carbohydrate
Snack: _____ unit(s) per _____ grams of carbohydrate
Lunch: _____ unit(s) per _____ grams of carbohydrate
Snack: _____ unit(s) per _____ grams of carbohydrate
Dinner: _____ unit(s) per _____ grams of carbohydrate
Snack: _____ unit(s) per _____ grams of carbohydrate
Night: _____ unit(s) per _____ grams of carbohydrate

Correction Dose: 1.0 unit (s) of insulin for every _____points

Target(s): _____mg/dl _____mg/dl

Your questions/concerns today:

_____

_____

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

_____

_____

Please Turn Over

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?

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

Please list current *Diabetes* medications and supplies:

- ☐ Humalog Form: ☐ Pen ,type_____ ☐ Vial
- ☐ Novolog Form: ☐ Pen ,type_____ ☐ Vial
- ☐ Lantus Form: ☐ Pen ,type_____ ☐ Vial
- ☐ Levemir Form: ☐ Pen ,type_____ ☐ Vial
- ☐ Strips for meter (type)_____
- ☐ Lancets (type)_____
- ☐ Syringes (type)_____
- ☐ Pen needles (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_____