Children's Hospital and Health System™ | Medical College of Wisconsin

Children's Specialty Group™

Child's name:_____

Date of Birth:_____

Date of Visit:_____

# Information to bring to Clinic Appointments:

**Please complete the following worksheet so that you will be able to get the most out of your clinic appointment!**

## 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 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## Insulin per carbohydrate ratio:

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

**Correction Dose:** **1.0** unit (s) of insulin for every _____mg/dl

**Target Blood Sugar Range:** _____ to _____mg/dl

**Target Blood sugar number:** _____mg/dl

## Insulin Dose:

Average/usual total insulin dose:

| Insulin | Breakfast | Snack | Lunch | Snack | Dinner | Snack |
|---|---|---|---|---|---|---|
| Novolog/ Humalog | | | | | | |
| Lantus/ Levimir | | | | | | |

***** If you use a dosing chart/grid to figure out your insulin doses – please bring to clinic visit*****

**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.*****

**Other Medications** ☐ **None**

| Medication Name (please print clearly) | Dose | Route (How given) | How Often Is it taken? | Reason for use/comments |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Allergies** ☐ **No Known Allergies**

| Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**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_____