**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***

<table>
<thead>
<tr>
<th></th>
<th>Breakfast</th>
<th>Snack</th>
<th>Lunch</th>
<th>Snack</th>
<th>Dinner</th>
<th>Snack</th>
<th>Night</th>
<th>Night</th>
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</tbody>
</table>

**Insulin per carbohydrate ratio:**

- **Break:** ________ unit(s) per ________ serving or grams of carbohydrate
- **Snack:** ________ unit(s) per ________ serving or grams of carbohydrates
- **Lunch:** ________ unit(s) per ________ serving or grams of carbohydrates
- **Snack:** ________ unit(s) per ________ serving or grams of carbohydrates
- **Dinner:** ________ unit(s) per ________ serving or grams of carbohydrates
- **Snack:** ________ unit(s) per ________ serving or grams of carbohydrates
- **Night:** ________ unit(s) per ________ serving or grams of carbohydrates

**Target Blood Sugar Range:** ________ to ________ mg/dl

**Target Blood sugar number:** ________ mg/dl (what number you subtract for correction)

**Correction Factor:** 1.0 unit(s) of insulin for every ________ mg/dl (what number you divide blood sugar by)

**Insulin Dose:**

Average/usual total insulin dose:

<table>
<thead>
<tr>
<th>Insulin</th>
<th>Breakfast</th>
<th>Snack</th>
<th>Lunch</th>
<th>Snack</th>
<th>Dinner</th>
<th>Snack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novolog/</td>
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<tr>
<td>Humalog</td>
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<tr>
<td>Lantus/</td>
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<td>Levimir</td>
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</tbody>
</table>

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

**What changes have you made since your last visit?**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**Your questions/concerns today:**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

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

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
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.)

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _______________________________</td>
<td>4. _______________________________</td>
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<tr>
<td>2. _______________________________</td>
<td>5. _______________________________</td>
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<tr>
<td>3. _______________________________</td>
<td>6. _______________________________</td>
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</tbody>
</table>

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.)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

(See 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 _______________________________