# Clinical Summary for New Health Care Team

ENDOCRINE SOCIETY

*Form to be completed, signed, and dated on last page by referring provider and patient.*
*Patient and family to review and give completed form to new adult health care provider.*

**Patient Name** _____ **Date of Birth** _____

## Diabetes Type

☐ Type 1 ☐ Type 2 ☐ Other _____

Antibodies: ☐ Positive ☐ Negative ☐ Not Performed

Date Diabetes Diagnosed _____

## Problem List and Date of Onset

_____

_____

_____

_____

_____

_____

## Type of Insulin Therapy

*If applicable, please also attach pump settings/specific insulin regimen.*

| Pump Therapy | Type of Pump: | Insulin: | |
|---|---|---|---|
| Total Average Daily Dose | Units/kg/day | Total/% Basal | Insulin Brand |
| Ins:Carb ratio<br>1 U: grams | Sensitivity Factor (CF)<br>1 U: mg/dL | Target Sugar | |

| Basal/Bolus Therapy | | |
|---|---|---|
| Rapid/Short Acting Insulin<br>☐ Humalog<br>☐ Novolog<br>☐ Apidra<br>☐ Regular | Long Acting Insulin<br>☐ Lantus _____units ☐ AM ☐ PM<br>☐ Levemir _____units ☐ AM ☐ PM<br>☐ Humulin R U-500 _____unit ☐ AM ☐ PM<br>☐ NPH _____unit ☐ AM ☐ PM | Average Units/kg/day |
| Ins:Carb ratio<br>1 U: grams | Sensitivity Factor (CF)<br>1 U: mg/dL | Target Sugar |

**Patient Name** _____ **Date of Birth** _____

| Other Insulin Regimens | Insulin Name | Dosage and Schedule |
|---|---|---|
| Pre-mixed Insulin | | Units _____ Time _____<br>Units _____ Time _____ |
| Long Acting Insulin<br>☐ Syringe ☐ Pen | ☐ NPH<br>☐ Lantus<br>☐ Levemir | Units _____ Time _____<br>Units _____ Time _____ |
| Rapid Acting Insulin<br>☐ Syringe ☐ Pen | ☐ Humalog<br>☐ Novolog<br>☐ Apidra<br>☐ Regular | Units _____ Time _____<br>Units _____ Time _____ |

| All Other Medications | Dosage | Schedule | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Allergies/Alerts: _____

_____

## Self-Monitoring *(check all that apply)*

Blood Glucose Frequency
Prescribed Frequency ☐ 0-1/day ☐ 2-3/day ☐ 3-4/day ☐ >5-6/day
Performed Frequency ☐ 0-1/day ☐ 2-3/day ☐ 3-4/day ☐ >5-6/day
Meter _____

Continuous Glucose Monitoring?
☐ No ☐ Yes, Currently ☐ Yes, In the Past
If currently: ☐ Sometimes? ☐ Most of the Time?
If in the past: When: _____
Device: _____

Ketones
☐ Blood ☐ Urine

## Recent Clinical Exam/Test Results

| Blood Pressure (Date) | Dilated Eye Exam (Date) | Sensory Foot Test (Date) |
|---|---|---|
| Current Weight (Date) | Height (Date) | BMI (Date) |

**Patient Name** _____ **Date of Birth** _____

## Most Recent Laboratory Values

| Date | A1C (2 values) | Chol/LDL/HDL/Trig | Urine Microalb/Cr Ratio | Cr/eGFR |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Other Laboratory Evaluation

| Date | Thyroid Function Testing | Thyroid Antibody Screening | Celiac Screening | Other |
|---|---|---|---|---|
| | | | | |
| | | | | |

Additional Comments/Information such as X-rays, Biopsies, and Other Test Results: _____

_____

Other Exam/Test Results: _____

_____

## Past Diabetes History *(check all that apply)*

**Initial Diagnosis**

Hospitalization ○ No ○ Yes

Diabetic Ketoacidosis ○ No ○ Yes

**Diabetes-related Hospitalizations (Occurring post-diagnosis)** ○ Never ○ 1-2 ○ 3-4 ○ 5+

Past Year? ○ No ○ Yes

Cause of Hospitalization:

DKA ○ No ○ Yes

Recurrent DKA? ○ No ○ Yes ☐ 1-2/year ☐ >2/year

Severe Hypoglycemia ○ No ○ Yes

Sick Day Management ○ No ○ Yes

Other: _____

**Site Issues**

| | | | | | | |
|---|---|---|---|---|---|---|
| Recurrent Site Infection | ☐ No | ☐ Yes | ☐ Arm | ☐ Abdomen | ☐ Buttock | ☐ Leg |
| Lipohypertrophy | ☐ No | ☐ Yes | ☐ Arm | ☐ Abdomen | ☐ Buttock | ☐ Leg |
| Atrophy | ☐ No | ☐ Yes | ☐ Arm | ☐ Abdomen | ☐ Buttock | ☐ Leg |

**Patient Name** _____ **Date of Birth** _____

**Other Concerns**

| | | |
|---|---|---|
| Hypoglycemia Unawareness | ◯ No | ◯ Yes |
| Fear of Needles | ◯ No | ◯ Yes |
| Fear of Hypoglycemia | ◯ No | ◯ Yes |

**Participation in Clinical Research?** ◯ No ◯ Yes ☐ Current ☐ Past

Which study? _____

**Patient/Family Comments** _____

_____

**Most Recent Diabetes Education Consult** _____

**Most Recent Nutrition Consult** _____

**Are there additional issues that you would like to discuss about this patient?** ☐ No ☐ Yes

If yes, please call Referring physician _____

Phone Number _____

**Notes** _____

_____

_____

**Has this information been reviewed with the patient?** ☐ No ☐ Yes

Pediatric Providers: *Please attach a clinical summary with any relevant additional clinical information, family and social history, etc.*

**Patient Signature and Date**

_____

**Referring Physician Signature and Date**

_____

**Contact Information**

_____

_____

_____

_____

*Attach Business Card Here*

IN COOPERATION WITH

American Association of Diabetes Educators · ACP American College of Physicians · American Academy of Pediatrics Dedicated to the Health of All Children™ · American Diabetes Association. · Hormone Health Network Keep your body in balance · ISPAD International Society for Pediatric and Adolescent Diabetes · JDRF Improving Lives. Curing Type 1 Diabetes. · PES Pediatric Endocrine Society