# Clinical Summary for New Health Care Team

*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 | Long Acting Insulin | Average Units/kg/day |
| ☐ Humalog | ☐ Lantus _______units ☐ AM ☐ PM | |
| ☐ Novolog | ☐ Levemir ______units ☐ AM ☐ PM | |
| ☐ Apidra | ☐ Humulin R U-500 ______unit ☐ AM ☐ PM | |
| ☐ Regular | ☐ NPH ______unit ☐ AM ☐ PM | |
| 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