PATIENT TELEPHONE APPOINTMENT PACKAGE

If you have changed from a regular clinic appointment to a phone visit, please complete the following forms and email them back to achdiabetesnurse@ahs.ca.

If you are using an Insulin Pump:

1. Complete the clinic form in this package by clicking on the left tab "Patient Clinic Package (Pump)". You can also download the package directly from our website by clicking here.
2. Download your pump to Carelink (Medtronic) or Diasend (Omnipod and Tandem) and send a PDF of the reports for the past 2 weeks
3. If you are using CGM, send us a PDF copy of the reports for the past 2 weeks

If you are a Non-pump user

1. Complete the clinic form in this package by clicking on the left tab "Patient Clinic Package (Non Pump)". You can also download the package directly from our website by clicking here.
2. Download your CGM or Meter and send us a PDF copy of the reports, **or** you can take a picture of the past two weeks of your logbook

A quick reminder that once you complete the forms in this package, please save the file to your desktop and then email back to us at achdiabetesnurse@ahs.ca.

Sincerely,

Diabetes Clinic, Alberta Children's Hospital

Alberta Children's Hospital
Diabetes Clinic

Alberta Children's Hospital
Diabetes Clinic

RECORDING FOR CLINIC VISITS

1. A two week detailed logbook including blood sugars, how much insulin your child is taking and how many carbs are eaten throughout the day.
2. If you are currently using Libre/Dexcom please complete this log sheet AND attach your Libre/Dexcom reports.
3. Pumpers can download following reports
4. Medtronic - Assessment & Progress, Weekly Review, Meal Bolus Wizard, Dashboard Report, Adherence Report, Sensor & Meter Overview & Logbook **OR** Bundled Reports if using 670 System.
5. Diasend/Glooko – Pump settings, comparison Logbook/table compilation.

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Blood Glucose, insulin, and Carbohydrate intake Log

Example 1*: Patients on NPH or Humulin N (clear and Cloudy)*

Date		Night		Breakfast		Lunch		Supper	Bed		**Basal Insulin**	Comments
	Time	0100		0800	945	1200	330	600pm		900pm		
	B/G	6.5		6.8		9.2		17.1		5.5		
	Carbs			60	30	45	25	90		20		
	Insulin+			4H 20N				6H+3H		6.5N		

Example 2: *Patients on Lantus,Toujeo Levemir, Tresiba, or Basalgar ("Basal/bolus")*

Date		Night		Breakfast		Lunch		Supper	Bed		**Basal Insulin**	Comments
	Time	0100		0800		1200	330	600pm		900pm		
	B/G	6.5		6.8		9.2	5.5	17.1		5.5	20 Lantus @9pm	
	Carbs			60		45	30	90		20		
	Insulin +			4H (1:15)		3H (1:15)	2H (1:15)	6H+3H (1:15) + correction		1H		

Carbohydrates

- Record the amount and time that Carbohydrate was eaten. Include meals and snacks.

Insulin

- Record the time that insulin was given.
- If the blood sugar is above target, record BOTH the insulin given for food and the insulin given to correct the high blood sugar.
- See example above - At Supper: 6 units was given for a supper of 90 grams of Carbs+ 3 extra units to correct the blood sugar of 17.1 mmol/L.

Basal Insulin

- Record the usual time of day that Lantus/Toujeo/Levemir/Tresiba/Basaglar is given.
- You do not need to record basal insulin every day, unless you have made changes

Comments

- Record special occasions (eg. Birthday parties), activity or illness in this section

Blood Glucose Log for ____ **Insulin Carb Ratio: Breakfast______ Lunch ______ Dinner______ Bedtime______**

Date		Night		Breakfast		Lunch		Supper		Bed		Basal Insulin	Comments:
Mon	Time												
	B/G												
	CHO												
	Bolus +												

Date		Night		Breakfast		Lunch		Supper		Bed		Basal Insulin	Comments:
Tue	Time												
	B/G												
	CHO												
	Bolus +												

Date		Night		Breakfast		Lunch		Supper		Bed		Basal Insulin	Comments:
Wed	Time												
	B/G												
	CHO												
	Bolus +												

Date		Night		Breakfast		Lunch		Supper		Bed		Basal Insulin	Comments:
Thu	Time												
	B/G												
	CHO												
	Bolus +												

Date		Night		Breakfast		Lunch		Supper		Bed		Basal Insulin	Comments:
Fri	Time												
	B/G												
	CHO												
	Bolus +												

Date		Night		Breakfast		Lunch		Supper		Bed		Basal Insulin	Comments:
Sat	Time												
	B/G												
	CHO												
	Bolus +												

Date		Night		Breakfast		Lunch		Supper		Bed		Basal Insulin	Comments:
Sun	Time												
	B/G												
	CHO												
	Bolus +												

Addressograph here

PATIENT CLINIC QUESTIONNAIRE (NON-PUMP)

Date:	Who is completing this form today?
What would you like to discuss today?	
Name of family doctor/pediatrician:	
Date of last eye exam?	School grade?
Any allergies? If so, please describe:	
List all current activities in which your child participates:	

List all **non diabetes medication,** including, prescribed medications, multivitamins, herbal supplements.
Medication Name/Dose and Frequency

List your **child's insulin dose.**

Meal	*Insulin: type/dose/Insulin carb ratio if using*	*ISF, correction factor or sliding scale*
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		
Bedtime		

What are your carb goals, or carb range at meals and snacks?

Breakfast	*a.m. snack*	*Lunch*	*p.m. snack*	*Supper*	*Bedtime*

Insulin	*Always*	*Often*	*Sometimes*	*Never*
Does your child give his/her own **insulin**?	❒	❒	❒	❒
Is insulin given before meals?	❒	❒	❒	❒
Which sites are you using?	❒ Arms	❒ *Legs*	❒ *Buttocks*	❒ *Tummy*

Who is most responsible for:	***Shared***	***Parent***	***Child***	***Nobody***
• Preparing food?	❒	❒	❒	❒
• calculating carb at meals/snacks?	❒	❒	❒	❒
• calculating insulin dose for carb eaten?	❒	❒	❒	❒
• calculating correction dose for high blood sugars?	❒	❒	❒	❒

What tools do you use to calculate carb content of foods?

❒ Food labels ❒ Measuring Cups ❒ Binder from diabetes clinic ❒ Other:

❒ Scales ❒ "Eyeball" ❒ Carb-counting books/software/apps

Since your child's last diabetes clinic visit, has she/he had:	***No***	***Yes***
• any visit(s) to the hospital?	❒	❒
• high blood sugars with ketones?	❒	❒
• a low blood sugar with confusion, loss of consciousness or seizure?	❒	❒

On average, how many lows per week?

How do you treat low blood sugar? (with how many grams of carb?)

	Always	***Often***	***Sometimes***	***Never***
Does your child wear a medic alert?	❒	❒	❒	❒
Does your child recognize low blood sugars?	❒	❒	❒	❒
Do you or your child carry low treatments?	❒	❒	❒	❒

When would you test for ketones? ❒ During Illness ❒ When blood sugar is greater than 14 ❒ Never

Do you have up-to-date ketone testing strips?	❒ Yes	❒ No	❒ Don't Know
Do you have an up-to-date Glucagon Kit?	❒ Yes	❒ Don't Know	❒ No
Do you need a prescription renewal?	❒ No	❒ Don't Know	❒ Yes

Does your child have**:**	**No**	**Somewhat**	**Yes**
• issues with insulin injections or finger pokes?	❒	❒	❒
• a fear of low blood sugars?	❒	❒	❒
• anxiety or depression?	❒	❒	❒
• concerns about body weight and/or appearance?	❒	❒	❒

Are there family events/issues that are impacting diabetes management ? ❒No ❒Yes: If yes, describe:

We routinely ask all families about domestic violence. Domestic violence can include physical abuse, but also can include sexual, emotional or spiritual abuse, controlling or threatening behavior, financial misuse and control, or neglect.

Is this a problem for you? ❒No ❒Yes

Reviewed by: ____________________

Alberta Children's Hospital Diabetes Clinic

Alberta Children's Hospital
Diabetes Clinic
2888 Shaganappi Trail, NW
Calgary, AB T3B 6A8
Fax: 403-955-7639

Dear Parent,

In order to assist the Dietitian in evaluating your child's intake and to be more effective during your clinic visit, we request you provide a three day food diary indicating **ACTUAL FOOD INTAKE**. Prior to each Diabetes Clinic appointment, please complete the attached food diary form (see reverse side).

To complete the form, please follow these instructions and the example below.

1. **Record** usual time of meal, carbohydrate goals, insulin/carb ratio (if used) and usual insulin dose in left-hand column.
2. **Record** blood glucose test results (BG) in upper left-hand boxes.
3. ***Record** food intake for 3 days. Specify types and amounts (weight or volume) and **the carbohydrate count of all foods eaten**. To record ACTUAL food intake:
   - ✓ Indicate the ***amount*** and ***kind of food*** eaten in weight or cups using imperial or metric measurements, e.g. 50g (weight) Kellogg's Rice Krispies.
   - ✓ Indicate preparation method, e.g. 1/2 cup ***boiled*** potatoes.
   - ✓ Indicate butter fat content of dairy products, e.g. 1/2 cup ***2%*** milk.
   - ✓ If eating out - indicate restaurant and food eaten (be as specific as possible!), e.g. 1/8th of 10" thin crust ***Boston Pizza*** - pineapple, ham and cheese.
   - ✓ Provide the recipe (including all ingredients and the yield) of homemade dishes such as casseroles or baking.
4. **Record** activity and multivitamins/herbal supplements taken at the bottom the page.

	DATE:	Carb
Breakfast Time: 7:30 • Carb Goals 65 g • Insulin/carb ratio ______ • Usual Insulin 6H 21N	BG: 6.5 2 slices of whole wheat toast 1 Tbsp Kraft peanut butter 2 tsp Smucker's Strawberry No Sugar Added Jam 1 cup 2% milk 1 small banana (101g) TOTAL	30g 3g 4g 12g 20g 69g

Completing the attached food diary: The better prepared we are for your appointment, the more you will benefit from our time spent together. Please return the completed food diary **before** your clinic visit. If you are unable to return the log to us, please bring it in with you for your appointment.

If you **email** the food diary:	If you **mail**, **fax** or **deliver** the food diary:
• In order to comply with Alberta Health Services privacy regulations, we are unable to accept any electronic (emailed) document containing a patient's name.	• Make sure your child's name and date of your upcoming visit is filled in.
• Given this restriction, we are able to accept documents emailed with an appointment date.	• Our mailing address and fax number is shown in the top right corner of this page.
• Please type your appointment date in the email to your Dietitian (see email addresses below).	• You can drop off the printed diary to the reception desk at the Clinic.

If you have questions, please call. Thank you for your cooperation.

Kelly Grebenc-Rukavina	Deanna Langille	Lesley McCoy	Julia Mercer
RD, CDE	**RD, CDE**	**RD, CDE**	**RD, CDE**
Clinical Dietitian	Clinical Dietitian	Clinical Dietitian	Clinical Dietitian
403-955-7340	403-955-7332	403-955-2984	403-955-3253
Email:Kelly.Grebenc@albertahealthservices.ca	Email:Deanna.Langille@albertahealthservices.ca	Email:Lesley.McCoy@albertahealthservices.ca	Email:Julia.Mercer@albertahealthservices.ca

Alberta Children's Hospital Diabetes Clinic

Food Diary for: ______________________ **Appointment Date:** __________________

*(Please see **instructions on how to complete this food diary**.)*

	DATE:	Carb	DATE:	Carb	DATE:	Carb
Breakfast Time:________ • Carb Goals __________ • Insulin/carb ratio _______ • Usual Insulin ___________	BG:		BG:		BG:	
Snack **Time:**_______ • Carb goals ____________ • Insulin/carb ratio _______						
Lunch: Time:_______ • Carb Goals ___________ • Insulin/carb ratio _______ • Usual Insulin __________	BG:		BG:		BG:	
Snack **Time:**_______ • Carb goals ____________ • Insulin/carb ratio _______						
SUPPER **Time:**_______ • Carb Goals ___________ • Insulin/carb ratio _______ • Usual Insulin ___________	BG:		BG:		BG:	
Snack Time:______ • Carb goals ____________ • Insulin/carb ratio _______ • Usual Insulin __________	BG:		BG:		BG:	
Activity: • Type • Time **Multivitamins/Herbal supplements**:						

Alberta Children's Hospital
Diabetes Clinic

Master Copy

PATIENT CLINIC QUESTIONNAIRE (PUMP)

Date:	Who is completing this form today?
What would you like to discuss today?	
Name of your family doctor/pediatrician:	
Date of last eye exam?	School grade?
Any allergies? If so, please describe:	
List all **current activities** in which your child participates.	

List all **non diabetes medication** including prescribed medications, multivitamins, herbal supplements.
Medication Name/Dose and Frequency

Insulin Pump Settings: Complete or attach report from download						
Basal rates		**Carb Ratio**:		**Total daily** dose for the last 5 days	**What is the:**	
Time	Rate	Time	Ratio		• total daily '**basal' dose**?	
				Day 1:	• **ISF** (correction)?	
				Day 2:	• **Daytime** target?	
				Day 3:	• **Night** target?	
				Day 4:		
				Day 5:		

	Always	***Often***	***Sometimes***	***Never***
Is your child supervised when bolusing?	❒	❒	❒	❒
Is insulin given before meals?	❒	❒	❒	❒
Do you follow the bolus recommendations from the pump?	❒	❒	❒	❒

What is the **range of carbohydrate** eaten at each meal and snack?

Breakfast	***AM snack***	***Lunch***	***PM snack***	***Supper***	***Bedtime***

What tools do you use to calculate carb content of foods?

❒ Food labels
❒ Scales
❒ Measuring Cups
❒ "Eyeball"
❒ Binder from diabetes clinic
❒ Carb-counting books/software/apps
❒ Other:

Who is most responsible for:	***Shared***	***Parent***	***Child***	***Nobody***
• preparing food?	❒	❒	❒	❒
• calculating carb at meals/snacks?	❒	❒	❒	❒

What brand and type of pump do you use?	What type of infusion sets do you use?		
Which sites are you using?	❒ Arms	❒ Legs	❒ Buttocks ❒ Tummy
Are there any lumps at your sites?	❒ No	❒ Don't Know	❒ Yes
Have you had any infections at your sites?	❒ No	❒ Don't Know	❒ Yes
How often do you change the infusion set?	❒ every 2 days	❒ every 3 days	❒ every 4 days or more

Since your child's <u>last diabetes clinic</u> visit, has she/he had:	***No***	***Yes***
• any visit(s) to the hospital?	❒	❒
• high blood sugars with ketones?	❒	❒
• a low blood sugar with confusion, loss of consciousness or seizure?	❒	❒

On average, how many lows per week?

How do you treat low blood sugar? (with how many grams of carb?)

	Always	***Often***	***Sometimes***	***Never***
Does your child wear a medic alert?	❒	❒	❒	❒
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Alberta Children's Hospital Diabetes Clinic

Alberta Children's Hospital
Diabetes Clinic
2888 Shaganappi Trail, NW
Calgary, AB T3B 6A8
Fax: 403-955-7639

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   - ✓ Indicate preparation method, e.g. 1/2 cup ***boiled*** potatoes.
   - ✓ Indicate butter fat content of dairy products, e.g. 1/2 cup ***2%*** milk.
   - ✓ If eating out - indicate restaurant and food eaten (be as specific as possible!), e.g. 1/8th of 10" thin crust ***Boston Pizza*** - pineapple, ham and cheese.
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Kelly Grebenc-Rukavina RD, CDE	**Deanna Langille RD, CDE**	**Lesley McCoy RD, CDE**	**Julia Mercer RD, CDE**
Clinical Dietitian 403-955-7340 Email:Kelly.Grebenc@albertahealthservices.ca	Clinical Dietitian 403-955-7332 Email:Deanna.Langille@albertahealthservices.ca	Clinical Dietitian 403-955-2984 Email:Lesley.McCoy@albertahealthservices.ca	Clinical Dietitian 403-955-3253 Email:Julia.Mercer@albertahealthservices.ca

Alberta Children's Hospital
Diabetes Clinic

Food Diary for: ______________________ **Appointment Date:** __________________

(Please see ***instructions on how to complete this food diary****.)*

	DATE:	Carb	DATE:	Carb	DATE:	Carb
Breakfast Time:________ • Carb Goals __________ • Insulin/carb ratio _______ • Usual Insulin __________	BG:		BG:		BG:	
Snack **Time:**_______ • Carb goals ____________ • Insulin/carb ratio _______						
Lunch: Time:_______ • Carb Goals __________ • Insulin/carb ratio _______ • Usual Insulin _________	BG:		BG:		BG:	
Snack **Time:**_______ • Carb goals ____________ • Insulin/carb ratio _______						
SUPPER **Time:**_______ • Carb Goals __________ • Insulin/carb ratio _______ • Usual Insulin __________	BG:		BG:		BG:	
Snack Time:______ • Carb goals ____________ • Insulin/carb ratio _______ • Usual Insulin _________	BG:		BG:		BG:	
Activity: • Type • Time **Multivitamins/Herbal supplements**:						