



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



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.

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 +							
Tue	Time							
	B/G							
	CHO							
	Bolus +							
Wed	Time							
	B/G							
	CHO							
	Bolus +							
Thu	Time							
	B/G							
	CHO							
	Bolus +							
Fri	Time							
	B/G							
	CHO							
	Bolus +							
Sat	Time							
	B/G							
	CHO							
	Bolus +							
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 .		
<i>Meal</i>	<i>Insulin: type/dose/Insulin carb ratio if using</i>	<i>ISF, correction factor or sliding scale</i>
<i>Breakfast</i>		
<i>Snack</i>		
<i>Lunch</i>		
<i>Snack</i>		
<i>Dinner</i>		
<i>Snack</i>		
<i>Bedtime</i>		

What are your carb goals, or carb range at meals and snacks?					
<i>Breakfast</i>	<i>a.m. snack</i>	<i>Lunch</i>	<i>p.m. snack</i>	<i>Supper</i>	<i>Bedtime</i>

<i>Insulin</i>	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>
Does your child give his/her own insulin ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is insulin given <u>before</u> meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which sites are you using?	<input type="checkbox"/> Arms	<input type="checkbox"/> Legs	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Tummy

Who is most responsible for:	Shared	Parent	Child	Nobody
• Preparing food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• calculating carb at meals/snacks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• calculating insulin dose for carb eaten?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• calculating correction dose for high blood sugars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 <u>last diabetes clinic</u> visit, has she/he had:	No	Yes
• any visit(s) to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
• high blood sugars with ketones?	<input type="checkbox"/>	<input type="checkbox"/>
• a low blood sugar with confusion, loss of consciousness or seizure?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child recognize low blood sugars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or your child carry low treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When would you test for ketones?	<input type="checkbox"/> During Illness <input type="checkbox"/> When blood sugar is greater than 14 <input type="checkbox"/> Never			
Do you have up-to-date ketone testing strips?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Do you have an up-to-date Glucagon Kit?	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> No	
Do you need a prescription renewal?	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes	

Does your child have:	No	Somewhat	Yes
• issues with insulin injections or finger pokes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• a fear of low blood sugars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• anxiety or depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• concerns about body weight and/or appearance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
28 Oki Drive, NW
Calgary, AB T3B 6A8
Fax: 403-955-7639

Dear Parent,

In order to assess your eating habits, it is most helpful to fill out a three (3) day food record, which tracks what you eat, how much you eat and when you ate it.

- You may need to measure or weigh some portions to determine more accurate portion sizes.
- Eat as you normally would while keeping your food records.
- Remember to complete the food record prior to Diabetes clinic appointment with the Dietitian. You can either email the food record or bring it with you to your appointment.

Instructions: To complete the Food Record 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: <u>7:30</u>	BG: <u>6.5</u>	
• Carb Goals <u>65 g</u>	2 slices of whole wheat toast	30g
	1 Tbsp Kraft peanut butter	3g
	2 tsp Smucker's Strawberry No Sugar Added Jam	4g
• Insulin/carb ratio _____	1 cup 2% milk	12g
	1 small banana (101g)	20g
• Usual Insulin <u>6H 21N</u>	TOTAL	69g

Recording your intake, bg and insulin doses helps us help you manage your diabetes.

If you have a question, please call or email.

Melissa Biddle RD	Deanna Langille RD	Julia Mercer RD, CDE	Karen Plett RD
Registered Dietitian	Registered Dietitian	Registered Dietitian	Registered Dietitian
403-955-7340 melissa.biddle@ahs.ca	403-955-7332 deanna.langille@ahs.ca	403-955-3253 julia.mercer@ahs.ca	403-955-2984 karen.plett@ahs.ca

	DATE	Carb	DATE	Carb	DATE	Carb
Breakfast Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: _____		BG: _____		BG: _____	
Snack Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____						
Lunch Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: _____		BG: _____		BG: _____	
Snack Time: _____ • Carb goals _____ • Insulin; carb ratio _____ and/or • Set insulin dose _____						
Supper Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: _____		BG: _____		BG: _____	
Snack Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: _____		BG: _____		BG: _____	
Activity: • Type _____ • Time _____ Multivitamins/Herbal supplements:						



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.

<i>Medication Name/Dose and Frequency</i>

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:		

	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>	
Is your child supervised when bolusing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is insulin given <u>before</u> meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you follow the bolus recommendations from the pump?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
What is the range of carbohydrate eaten at each meal and snack?					
<i>Breakfast</i>	<i>AM snack</i>	<i>Lunch</i>	<i>PM snack</i>	<i>Supper</i>	<i>Bedtime</i>

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

<input type="checkbox"/> Food labels	<input type="checkbox"/> Measuring Cups	<input type="checkbox"/> Binder from diabetes clinic	<input type="checkbox"/> Other:
<input type="checkbox"/> Scales	<input type="checkbox"/> "Eyeball"	<input type="checkbox"/> Carb-counting books/software/apps	

Who is most responsible for:	Shared	Parent	Child	Nobody
• preparing food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• calculating carb at meals/snacks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What brand and type of pump do you use?	What type of infusion sets do you use?			
Which sites are you using?	<input type="checkbox"/> Arms	<input type="checkbox"/> Legs	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Tummy
Are there any lumps at your sites?	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes	
Have you had any infections at your sites?	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes	
How often do you change the infusion set?	<input type="checkbox"/> every 2 days	<input type="checkbox"/> every 3 days	<input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
• high blood sugars with ketones?	<input type="checkbox"/>	<input type="checkbox"/>
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• concerns about body weight and/or appearance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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