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

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?	☐	☐	☐	☐
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
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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: 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

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
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Food Diary for: _____ **Appointment Date:** _____

	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**:						