Welcome to the Pediatric Diabetes Education Program. The following information will help us better understand the patient, your child. Please fill this form out as completely as possible and bring this to your child’s appointment. Please ask staff if you have any questions.

### General Information:
- **What type of diabetes does your child have?**
  - [ ] Type 1
  - [ ] Type 2
  - [ ] Other (explain):

- **When was your child diagnosed?** Date: ________________

- **Who came to the visit today?**
  - [ ] Mother
  - [ ] Father
  - [ ] No one
  - [ ] Other (specify):

- **What questions or concerns do you have today?**

### Learning:
- **What is the preferred language of your child?**
  - [ ] English
  - [ ] Spanish
  - [ ] Other (specify):

- **What is your (co-learner) preferred language?**
  - [ ] English
  - [ ] Spanish
  - [ ] Other (specify):

- **Does your child need an interpreter?**
  - [ ] No
  - [ ] Yes

- **Do you need an interpreter?**
  - [ ] No
  - [ ] Yes

- **Have you had previous education in diabetes?**
  - [ ] No
  - [ ] Yes If yes, how long ago and where?

- **How does your child prefer to learn?**
  - [ ] Listening
  - [ ] Reading
  - [ ] Demonstration
  - [ ] Seeing
  - [ ] Doing
  - [ ] Pictures/Video
  - [ ] Other (specify):

- **How do you prefer to learn?**
  - [ ] Listening
  - [ ] Reading
  - [ ] Demonstration
  - [ ] Seeing
  - [ ] Doing
  - [ ] Pictures/Video
  - [ ] Other (specify):

- **Check any barriers or considerations for learning:** Indicate whose barrier with P/G=Parent/Guardian or C=Child
  - [ ] No Barriers
  - [ ] Reading Issues
  - [ ] Language
  - [ ] Vision Impaired
  - [ ] Hearing Impaired
  - [ ] Learning Issues
  - [ ] Physical
  - [ ] Pain/Discomfort
  - [ ] Emotional
  - [ ] Cognitive
  - [ ] Memory
  - [ ] Financial
  - [ ] Available resources
  - [ ] Spiritual
  - [ ] Cultural
  - [ ] Meals/Diet
  - [ ] Alternative treatment

- **Are you interested in learning more about your child’s diabetes today?**
  - [ ] No
  - [ ] Yes

- **If yes, check which topics.**
  - [ ] Hyperglycemia (high blood sugar)
  - [ ] Hypoglycemia (low blood sugar)
  - [ ] Sick Day
  - [ ] Exercise
  - [ ] Medication
  - [ ] Smoking & Diabetes
  - [ ] Meal/Snack planning
  - [ ] Coping/Stress management
  - [ ] How to read food labels
  - [ ] Other (specify):

- **Describe your (co-learner) interest in learning:**
  - [ ] High
  - [ ] Medium
  - [ ] Low

### Social History:
- **Who lives at home with your child?**

- **In the last year, have there been changes in home life or family health since last visit?**
  - [ ] No
  - [ ] Yes If yes, please explain:

- **Are you having financial difficulties related to diabetes?**
  - [ ] No
  - [ ] Yes If yes, what?

- **Are there religious practices that could impact on your child’s diabetes care?**
  - [ ] No
  - [ ] Yes If yes, please explain:

- **What is the most difficult part of caring for your child’s diabetes?**
**Assessment – Diabetes Self-Management Education (DSME)**

Does your child attend school/day care? ☐ No ☐ Yes If yes, grade: ______

Has your child missed days due to diabetes? ☐ No ☐ Yes If yes: _______ days / this year

How do you and your child feel about having diabetes? ____________________________

<table>
<thead>
<tr>
<th>How is your stress level?</th>
<th>Low ☐</th>
<th>Medium ☐</th>
<th>High ☐</th>
<th>Explain: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How is your child’s stress level?</th>
<th>Low ☐</th>
<th>Medium ☐</th>
<th>High ☐</th>
<th>Explain: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How do you handle stress?</th>
<th>____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does your child handle stress?</th>
<th>____________________________</th>
</tr>
</thead>
</table>

Does your child drive a car? ☐ No or Not applicable ☐ Yes

If yes, check any precautions: ☐ Check blood sugar before driving ☐ Keep carbs in the car

<table>
<thead>
<tr>
<th>Does your child:</th>
<th>Use drugs?</th>
<th>☐ No (not that you are aware of) ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Use tobacco?</th>
<th>☐ No (not that you are aware of) ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Drink alcohol?</th>
<th>☐ No (not that you are aware of) ☐ Yes</th>
</tr>
</thead>
</table>

**Diabetes Care and Monitoring:**

How many times in last week has your child missed an insulin dose? ☐ Rarely ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8

<table>
<thead>
<tr>
<th>How often do you/your child check his/her blood glucose (bg) per day?</th>
<th>Rarely ☐ 1-4 ☐ 5-7 ☐ 8-9 ☐ &gt;9</th>
</tr>
</thead>
</table>

Does your child use CGM? ☐ No ☐ Yes If yes, brand name ____________________________

<table>
<thead>
<tr>
<th>Are they using continuously ☐ or intermittently ☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you/your child keep a bg log? ☐ No ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you review the bg data? ☐ No ☐ Yes If yes, how often? ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What type of meter does your child use?</th>
<th>____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What sites does your child use for injections or pump sites?</th>
<th>☐ Abdomen ☐ Buttocks ☐ Arm ☐ Leg</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does your child have symptoms with high blood sugars?</th>
<th>☐ No ☐ Yes If yes, explain: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What do you do when your child has a high blood sugar?</th>
<th>____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does your child have symptoms with low blood sugars?</th>
<th>☐ No ☐ Yes If yes, explain: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What do you do when your child has a low blood sugar?</th>
<th>____________________________</th>
</tr>
</thead>
</table>

At what number? __________ Have the symptoms changed over time? ☐ No ☐ Yes

<table>
<thead>
<tr>
<th>How often do you and your child count carbohydrates?</th>
<th>Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How often do you and your child weigh or measure foods?</th>
<th>Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How often do you and your child read food labels?</th>
<th>Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does your child avoid certain foods?</th>
<th>☐ No ☐ Yes If yes, what? ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is your child on a gluten-free diet?</th>
<th>☐ No ☐ Yes If yes, received education? ☐ No ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How often does your child exercise?</th>
<th>______ Days per week Type of exercise: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How does your child manage blood sugar with exercise?</th>
<th>☐ Pre-exercise monitoring ☐ Snacks</th>
</tr>
</thead>
</table>

| ☐ Temporary basal rate | ☐ Uncovered carbohydrate (Describe: ____________________________ ) |
**UNIVERSITY OF MICHIGAN HEALTH SYSTEM**  
**Pediatrics - Endocrinology**  
**Assessment – Diabetes Self-Management Education (DSME)**

### Review of Systems:
Please check all symptoms your child is having or has had since the last visit:

- [ ] Abdominal pain  
- [ ] Allergies  
- [ ] Anxiety  
- [ ] Bed wetting  
- [ ] Chest pain  
- [ ] Cough  
- [ ] Dental problems  
- [ ] Depression/Hopeless  
- [ ] Diarrhea  
- [ ] Difficulty breathing  
- [ ] Difficulty feeling low blood sugars  
- [ ] Dry skin  
- [ ] Excessive weight gain  
- [ ] Fatigue  
- [ ] Foot problems (ex. ingrown toenails)  
- [ ] Headaches  
- [ ] Hypoglycemia (severe)  
- [ ] Increased thirst  
- [ ] Increased urination  
- [ ] Infections  
- [ ] Injection or pump site issues  
- [ ] Irregular period (females)  
- [ ] Joint pain  
- [ ] Loss of interest or pleasure in doing things  
- [ ] Rash  
- [ ] Seizures  
- [ ] Sleep problems  
- [ ] Stress  
- [ ] Other (list):  

Describe checked symptoms above:

---

### Medical History

When was your child’s last (give approximate date):

- Eye examination? 
- Dentist visit? 
- Flu shot? 
- Pneumococcal vaccine?

Does your child wear Medical Alert Identification?  
[ ] No  
[ ] Yes

Has your child had moderate or large ketones since last visit?  
[ ] No  
[ ] Yes  
If yes, what happened?

Hospital admission or Emergency Department visit since last visit?  
[ ] No  
[ ] Yes  
If yes, describe:

How often has your child had low blood sugars since last visit?  
[ ] Rarely  
[ ] 1-2 times weekly  
[ ] 3-4 times weekly  
[ ] Daily  
[ ] Other (specify):

Is there a pattern to the low blood sugars?  
[ ] No  
[ ] Yes  
Do they occur at a consistent time?  
[ ] No  
[ ] Yes

### Insulin Therapy

How does your child administer insulin?

- [ ] Injections (complete box 1 below)  
- [ ] Pump therapy (complete box 2 below)  
- [ ] Other insulin plan Describe (including doses):

Does your child take insulin before he/she eats?  
[ ] No  
[ ] Yes  
If yes, how many minutes before? ________

### Box 1: If your child is on Multiple Daily Injections, complete this section

What basal insulin does your child use?  
[ ] Lantus®  
[ ] Levemir®  
[ ] Other (specify):

For basal insulin, does your child use a pen or syringe?  
[ ] Pen  
[ ] Syringe

How much basal does your child use each day?  
____ total units per day

- Dose 1: _____ units at _____ AM/PM
- Dose 2: _____ units at _____ AM/PM

How do you calculate your child’s doses?  
[ ] Dosing chart  
[ ] Calculation  
[ ] Other (specify):

What rapid acting insulin does your child use?  
[ ] Apidra®  
[ ] Humalog®  
[ ] Novolog®

For rapid acting insulin, does your child use a pen or syringe?  
[ ] Pen  
[ ] Syringe

What is the average daily dose of rapid acting insulin?  
____ total units per day
Please fill in the tables below.

<table>
<thead>
<tr>
<th>Mealtime</th>
<th>Carb ratio</th>
<th>Set Dose</th>
<th>Time</th>
<th>Insulin Sensitivity Factor or Correction Factor</th>
<th>Target BG Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
<td>Morning</td>
<td>to</td>
<td></td>
</tr>
<tr>
<td>AM snack</td>
<td></td>
<td></td>
<td>Afternoon</td>
<td>to</td>
<td></td>
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<tr>
<td>Lunch</td>
<td></td>
<td></td>
<td>Early evening</td>
<td>to</td>
<td></td>
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<tr>
<td>Afternoon snack</td>
<td></td>
<td></td>
<td>Late evening</td>
<td>to</td>
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<tr>
<td>Supper</td>
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<td></td>
<td>Overnight</td>
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<tr>
<td>Evening snack</td>
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Box 2: If your child is on insulin pump therapy complete this section

Which type of pump do you use? ☐ Medtronic® ☐ Animas® ☐ Tandem® ☐ OmniPod® ☐ Other (specify): __________

Which type of infusion set do you use? ____________________________ How often do you change it? __________

Please fill in the tables below.

<table>
<thead>
<tr>
<th>Time</th>
<th>Basal Rate units/hour</th>
<th>Time</th>
<th>Carb Ratio</th>
<th>Time</th>
<th>Insulin Sensitivity Factor or Correction Factor</th>
<th>Time</th>
<th>Target BG Range</th>
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<td>AM/PM</td>
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<td>AM/PM</td>
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<td>AM/PM</td>
<td>to</td>
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<td>AM/PM</td>
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<td>AM/PM</td>
<td>to</td>
</tr>
</tbody>
</table>

Total daily basal units: __________  Total daily doses for last several days: __________, __________, __________, __________, __________

Printed Name of Person filling out form ____________________________ Date (mm/dd/yyyy) __________/________/________

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ DPOA for Healthcare ☐ Other (specify): ____________________________

FOR STAFF USE ONLY

Issues identified/Additional notes: ____________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Plan:
☐ Social work follow up  ☐ Basic teaching 1 & 2  ☐ Next scheduled diabetes clinic visit
☐ Psychology follow up  ☐ Support follow up  ☐ Dietitian  ☐ Type 2 class Date: ____________ Time: ____________
☐ School follow up  ☐ Other (specify): ____________________________

Referral/Physician order needed? ☐ Yes  ☐ No

Printed name and Signature of RN/RD ____________________________ Title ____________________________

Date: ____________ (mm/dd/yyyy) Time: ____________ A.M. / P.M.

Reviewed by Diabetes Health Team member (Printed name and Signature) ____________________________ Title ____________________________ Provider No. ____________________________

Date: ____________ (mm/dd/yyyy) Time: ____________ A.M. / P.M.