National Diabetes Education Program

A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Pediatric to Adult Diabetes Care
Clinical Summary for New Health Care Team

Form to be completed, signed, and dated on back page by referring physician and patient.
Patient and family to review and give completed form to new adult health care provider.

Patient Name: ________________________ **DOB**: ________________
Diabetes type: Type ❒ Type 2 ❒ Other: ______________ Date diabetes diagnosed: ______________

Problem List and Date of Onset

Complete for patients on Multiple Daily Injections:
Basal insulin: __________ Syringe or Pen: __________ Dose: __________ Schedule: __________
Bolus insulin: __________ Syringe or Pen: __________
Set dose: __________ [OR] Insulin-to-Carbohydrate Ratio: __________ Schedule: __________
Sensitivity Factor: __________Target for correction: __________ When to correct: __________

Complete for patients using Insulin Pump Therapy:
Make and Model Number: __________ Date of current pump acquisition: __________
Infusion sets used: __________ Insulin used in pump:__________
Basal rates:__________
Bolus set dose: __________[OR] Insulin-to-Carbohydrate Ratio: __________ Schedule: __________
Sensitivity Factor: __________Target for correction: __________ When to correct: __________

All Other Medications	Dosage	Schedule

Self-monitoring:
Blood glucose? No ❒ Yes ❒ Brand/Model __________ Frequency __________
Continuous glucose sensor? No ❒ Yes ❒ Brand/Model __________
Ketones checks? No ❒ Yes ❒ When __________
Other? __________

Recent Laboratory Values Check if lab reports are attached ❒

Date	A1C	Chol/LDL/HDL/Trig	Urine Albumin/Creat	T4/TSH	Celiac Panel

(over)

NATIONAL DIABETES EDUCATION PROGRAM (NDEP)
Clinical Summary for New Health Care Team
Continued

Recent Clinical Exam/Test Results:

Date	Weight	Height	BMI

Date	Blood Pressure	Dilated Eye Exam	Sensory Foot Exam

Other exam/test results: ______________________________

Most recent diabetes education consult: ______________________________

Most recent nutrition consult: ______________________________

Any significant hypoglycemic episodes in last 2 years? (e.g. seizure, coma, inability to care for oneself?) No ❒ Yes ❒
Circumstances: ______________________________

Does patient have hypoglycemic unawareness? No ❒ Yes ❒

Diabetes-related hospitalizations: ______________________________

History and cause of DKA: ______________________________

Allergies/alerts: ______________________________

Participation in clinical research? Past ❒ Current ❒ Which study? ______________________________

Additional comments/information such as X-rays, biopsies, and other test results: ______________________________

Patient/family comments: ______________________________

Psychosocial issues* (e.g. living situation, sexual activity, alcohol/tobacco/drug use, support system depression): ______________________________

**For more information on assessing psychosocial issues in adolescents, see the HEEADSSS assessment.*

Patient Signature and Date	Referring Physician Signature and Date
	Contact Information

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To learn more about living well with diabetes contact NDEP:
1-800-860-8747, TTY: 1-866-569-1162 or www.ndep.nih.gov