Insulin Pump Pre-Pump Assessment, English, Canada

PATIENT NAME:	DATE OF BIRTH (YYYY/MM/DD):	DATE OF ASSESSMENT (YYYY/MM/DD):
	___ ___ ___ ___/___ ___/___ ___	___ ___ ___ ___/___ ___/___ ___
HOME PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	**EMAIL ADDRESS:**	**NAME OF INTERVIEWER:**

Type of Assessment: ☐ Telephone ☐ In person ☐ Online

Medical History:

- Year of diagnosis of diabetes or years having diabetes? _____
- Type 1, type 2 or gestational diabetes? _____
- Other medical conditions: _____
- List of medications: _____
- Diabetes complications?

  ☐Retinopathy ☐Neuropathy ☐Nephropathy

  Other: _____
- Height? _____
- Weight? _____

What is your current insulin therapy regimen?

A. ☐ Insulin pump Brand _____
B. ☐ Injections # inject/day _____

What type of insulin do you take? Explain current regimen _____

_____

Have you taken diabetes education classes?

A. ☐ Yes B. ☐ No

If yes, check all the topics covered in the last 3 years:

☐Glucose meters ☐ Insulin Types ☐ Carb Counting
☐Diabetes Management ☐ Pump Therapy ☐ CGM

If you are a new pumper, whose idea was it for you to start insulin pump therapy (check all that apply)?

A. ☐ Self B. ☐ Healthcare provider (HCP) C. ☐ Family
D. ☐ Friends E. ☐ Other

Do you feel confident in your ability to manage your diabetes on a day-to-day basis?

A. ☐ Yes B. ☐ Sometimes C. ☐ No

Review the following concepts:

- Basal/Bolus Insulin Delivery
- Carb ratio
- Correction Factor or Insulin Sensitivity
- Blood Glucose Target
- Basal Rate

Have you been provided instruction on the following topics?

- Proper care of your infusion site ☐ Yes ☐ No
- Treating high and low blood glucose (Explain how) ☐ Yes ☐ No
- Troubleshooting high or low blood glucose ☐ Yes ☐ No
- Back-up plan for insulin injections ☐ Yes ☐ No
- Adjusting insulin for physical activity/use of temp rate ☐ Yes ☐ No
- Using an extended or combo bolus ☐ Yes ☐ No
- Checking for ketones ☐ Yes ☐ No

Do you feel confident in your ability to treat a low blood sugar, below 4.0 mmol/L? (Patient should be able to define this in their own words if answered "Yes" or "Sometimes")

A. ☐ Yes B. ☐ Sometimes C. ☐ No

Do you have any difficulty identifying symptoms of low blood glucose?

A. ☐ Yes B. ☐ No

If yes:

Have you been diagnosed with hypoglycemia unawareness? ☐ Yes ☐ No

Have you ever required Glucagon ☐ Yes ☐ No

Do you have a prescription for Glucagon ☐ Yes ☐ No?

What BG level do you tend to get symptoms of a low? _____ mmol/L

What are your symptoms of a low BG? _____

_____

(For patients on MDI) Have you been provided instruction on adjusting your insulin prior to your t:slim X2™ pump start?

A. ☐ Yes B. ☐ No

If yes, please explain.

_____

What concerns do you have about pump therapy? What are your goals after going on the pump?

When is your follow-up appointment with your Doctor or Clinic? _____

Pre-training homework (check all that apply):

- ☐ Work with diabetes educator on the following diabetes management skills: _____
- ☐ Review the User Guide
- ☐ Other

Please remember to bring all of the following items to your training appointment.

- ☐ t:slim X2 insulin pump
- ☐ Reference Guide
- ☐ Infusion sets Brand _____
- ☐ Site preparation products
- ☐ Cartridges
- ☐ Rapid-acting insulin vial
- ☐ BG meter Brand _____
- ☐ Saline (if required)
- ☐ Bring at least 2 sets of infusion sets and cartridges

SCHEDULED TRAINING:

DATE OF TRAINING (YYYY/MM/DD):	NAME OF TRAINER:
__ __ __ __/__ __/__ __	

COMPLETED BY:

TANDEM PUMP TRAINER NAME (PRINT):	
SIGNATURE: **X**	DATE (YYYY/MM/DD): __ __ __ __/__ __/__ __