



Queensland
Government

Clinical Summary – Transition Patient

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: ☐ M ☐ F ☐ I

The purpose of this form is to document the progress of the young person through the transition process from paediatric to adult care. This sheet must be filed into the patient record of the relevant organisation.

A photocopy of this progress sheet should be included with the young person's documentation/medical record:

- At time of transfer to an adult service; OR
- If transferred to another health service during the transition process.

The form is to be completed, signed and dated on the last page by referring practitioner.

Clinical Summary

Diabetes type ☐ Type 1 ☐ Type 2 ☐ Other (specify):
 Antibodies: ☐ Positive ☐ Negative ☐ Not performed
 Year of diagnosis: Age at diagnosis:

Allergies/alerts ☐ Nil known

Other conditions	Condition	Date of onset (if known)	Medications
	 / /	
	 / /	
	 / /	

Diabetes OHA

Type of insulin therapy (if applicable please also attach pump settings/specific insulin regimen)

Target BGL:

Basal/bolus therapy

Rapid/short acting insulin: ☐ Novarapid ☐ Fiasp ☐ Humalog ☐ Apidra
☐ Other (specify):

Long acting insulin: ☐ Optisulin (..... units) ☐ Levemir ☐ Toujeo ☐ AM ☐ PM

Mixed insulin: ☒ Ryzodeg 70/30 ☐ Other (specify):

Insulin/carb ratio 1U: grams Fixed doses:

Sensitivity factor (ISF) 1U: mmol/L Insulin active time:

Average total daily dose:

Pump therapy

Total average daily dose: Type of pump:

Insulin: Pump download attached: ☐ Yes ☐ No

Continuous glucose monitoring system

☐ Yes, currently ☐ Yes, in the past ☐ No

If Currently: ☐ Sometimes ☐ Most of the time ☐ Dexcom ☐ Medtronic ☐ Libre

If No, provide details:

Recent test results/annual health review	Observation/test	Measurement/result (please list latest results and date if known or provide attachment)	Date
	Blood pressure	 / /
	Dilated eye exam	 / /
	Sensory foot test	 / /
	Current weight	 / /
	Height	 / /
	BMI	 / /

Please tick (✓) any recent laboratory values and attach a copy of pathology results (if possible):

<input type="checkbox"/> HbA1c (2 values) / /	<input type="checkbox"/> Thyroid function testing / /
<input type="checkbox"/> Chol/LDL/HDL/Trig / /	<input type="checkbox"/> Thyroid antibody screening / /
<input type="checkbox"/> Urine microalb/CR ratio / /	<input type="checkbox"/> Coeliac screening / /
<input type="checkbox"/> Cr/eGFR / /	

Additional comments/information (such as x-rays, biopsies and other test results):

DO NOT WRITE IN THIS BINDING MARGIN

V1.00 - 11/2020
WINC Code:



SW1057

CLINICAL SUMMARY – TRANSITION PATIENT



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Clinical Summary *(continued)*

**Past diabetes
history** (please
tick all that apply)

Initial diagnosis

Hospitalisation:

☐ Yes ☐ No

Diabetic ketoacidosis:

☐ Yes ☐ No

Diabetes-related hospitalisations (occurring post-diagnosis): ☐ Never ☐ 1–2 ☐ 3–4 ☐ 5+

**Reason for
hospitalisation(s)**

DKA: ☐ Yes ☐ No

If Yes, how many times in the last 12 months?

Severe hypoglycaemia: ☐ Yes ☐ No

☐ Yes ☐ No

Hypoglycaemia unawareness: ☐ Yes ☐ No

Sick day management: ☐ Yes ☐ No

☐ Yes ☐ No

Other (specify):

Diabetes Educator Summary

Date of most recent consult: / /

Notes:

Clinician name:

Signature:

Date:

Dietitian Summary

Current weight:

Height:

Weight history:

Food allergies or intolerances:

Carbohydrate knowledge:

Any knowledge/skills gaps:

Any barriers to healthy eating:

Date of most recent consult: / /

Notes:

Clinician name:

Signature:

Date:

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Psychological Assessment

Fear of needles: ☐ Yes ☐ No

Fear of hypoglycaemia: ☐ Yes ☐ No

Date of last assessment: / /

Notes:

Additional Patient Information

School:

Year:

Work:

Sports:

Hobbies:

Driver's licence:

Attendance at diabetes camps:

Relationship status:

Patient Family/Support Network

Referring Practitioner

Clinician name:

Designation:

Contact details:

Signature:

Date:

Form Completed By (if different to Referring Practitioner)

Clinician name:

Designation:

Contact details:

Signature:

Date:

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