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

<table>
<thead>
<tr>
<th>Diabetes type</th>
<th>Type 1</th>
<th>Type 2</th>
<th>Other (specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibodies:</td>
<td>Positive</td>
<td>Negative</td>
<td>Nil known</td>
</tr>
<tr>
<td>Year of diagnosis:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at diagnosis:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Allergies/alerts

<table>
<thead>
<tr>
<th>Condition</th>
<th>Date of onset (if known):</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Diabetes OHA

<table>
<thead>
<tr>
<th>Type of insulin therapy</th>
<th>If applicable please also attach pump settings/specific insulin regimen</th>
</tr>
</thead>
</table>

#### Target BGL:

- **Basal/bolus therapy**
  - Rapid/short acting insulin: Novarapid, Flasp, Humalog, Apidra
  - Long acting insulin: Optisulin (specify units), Levemir, Toujeo, AM, PM
  - Mixed insulin: Ryzodeg 70/30, Other (specify)
  - Insulin/carbon ratio: 1U: grams
  - Sensitivity factor (ISF): 1U: mmol/L
  - Average total daily dose:

#### Pump therapy

- Total average daily dose: Type of pump: Novarapid, Other (specify)
- Insulin: Fixed doses: Novarapid
- Pump download attached: Yes, No
- If Yes, sometimes, Most of the time, Dexcom, Medtronic, Libre
- If No, provide details:

#### Continuous glucose monitoring system

- Yes, currently
- Yes, in the past
- No
- If Currently: Sometimes
- If No, provide details:

### Recent test results/annual health review

<table>
<thead>
<tr>
<th>Observation/test</th>
<th>Measurement/result</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dilated eye exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory foot test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- HbA1c (2 values)
- Thyroid function testing
- Chol/LDL/HDL/Trig
- Thyroid antibody screening
- Urine microalbumin/CR ratio
- Coeliac screening
- Cr/eGFR

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

________________________________________________________

________________________________________________________
Clinical Summary

Past diabetes history (please tick all that apply)

<table>
<thead>
<tr>
<th>Initial diagnosis</th>
<th>Hospitalisation:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic ketoacidosis:</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Diabetes-related hospitalisations (occurring post-diagnosis):</td>
<td>Never</td>
<td>1–2</td>
<td>3–4</td>
</tr>
</tbody>
</table>

Reason for hospitalisation(s)

| DKA: | Yes | No |
| Severe hypoglycaemia: | Yes | No |
| Hypoglycaemia unawareness: | Yes | No |
| Sick day management: | 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: ______/______/______
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: