

PEDIATRIC ASSESSMENT
Not Newly Diagnosed (NND) NEW REFERRAL
DIABETES CENTRE

Shading indicates optional completion when recorded elsewhere.
Use on all not newly diagnosed (NND) new referrals.
Use in conjunction with the Part 2 or Follow-up Assessment Form.

Unit No. _____
Name _____
Address _____
Sex _____ D.O.B. _____
HC No. _____

Name: _____ Date: _____

DEMOGRAPHIC INFORMATION

Mother: _____	Other: _____
Father: _____	Relationship: _____
Sibs (number, name, age): _____	Address: _____
_____	_____
_____	Province: _____
Address: _____	Postal Code: _____
_____	Phone: Res: _____
Province: _____	Bus: _____
Postal Code: _____	Occupation: _____
Phone: Res: _____	Hours of work: _____
Bus: (mother): _____	_____
(father): _____	_____
Occupation: (mother): _____	Hours of work: _____
(father): _____	Hours of work: _____
Drug plan: <input type="checkbox"/> social assistance <input type="checkbox"/> employment plan: _____	
<input type="checkbox"/> other: _____	<input type="checkbox"/> none
Pharmacy: _____	Phone: _____
Language spoken (if other than English): _____	Interpreter required: <input type="checkbox"/> N <input type="checkbox"/> Y
Ethnic background: _____	
School and grade: _____	Phone: _____
Signature: _____	
Person completing demographic information (if other than RN/PDt)	

DIABETES-RELATED INFORMATION

Age at onset: _____ Date of diagnosis: _____ Type of DM: type 1 type 2

Previous diabetes education: N Y (Complete part II or Follow-up Assessment form)

When: _____ Where: _____

Present symptoms: thirst ↑ urination fatigue weight loss

mood changes nausea/vomiting headaches blurred vision

DKA (pH < 7.35) recent infections: _____

other: _____ none

DIABETES-RELATED INFORMATION (cont)

Describe illness at present: _____

_____ no problems

FAMILY HISTORY

Diabetes: mother father
 sibs: _____
 grandparents: (M): mother father
(P): mother father
 other: _____ none
How has diabetes affected their lives? _____

CAD or PVD: N Y
Hypertension: N Y
Dyslipidemia: N Y
Thyroid disease: N Y
Other: _____

HEALTH STATUS

Medications (Non-DM - Include type/dose/frequency, OTCs, vit/min suppl): see Medication Sheet none
Allergies: (food, drugs, environmental): N Y (note) _____
_____ none
Medical problems: thyroid other (chronic illness/significant past illness/hospitalizations/disabilities):

_____ none

Date of last immunization: _____ see attached card Other preventative measures: _____

How often do you see the following:
GP? _____ Name: _____
Specialist(s)? _____ Name: _____
_____ Name: _____
Dentist? _____ Name: _____
Eye Specialist? _____ Name: _____
Other? _____ Name: _____

INSTRUCTED (see checklist)

See Part 2 or Follow-Up Form for additional information.

Signature: _____ Date: _____
Signature: _____ Date: _____