Paediatric Diabetes Registry

BORN Ontario

Patient Label Here

CREATE A PATIENT

DEMOGRAPHICS:

Family Name: _____

Given Name 1: _____

Given Name 2: _____

Given Name 3: _____

Given Name 4: _____

OHIP ID#: _____

ID#: _____

ID Type: ☐ Chart

Sex at Birth: *(Select One)*

☐ Male ☐ Female ☐ Unknown

Date of Birth: dd / mm /yyyy

☐ **No Fixed Address**

Postal Code: _____

City: _____

Province: _____

Country: _____

Telephone: _____

Alternative Telephone: _____

VISIT INFORMATION

***Date of Visit:** dd / mm /yyyy

***Visit Method:** *(Select One)*

☐ Video visit ☐ Clinic visit ☐ Telephone visit
☐ Community visit ☐ Other

If Other, please specify: _____

Providers in attendance for the visit: *(Select All That Apply)*

☐ Endocrinologist ☐ Pediatrician ☐ Nurse Practitioner
☐ Registered Dietitian ☐ Registered nurse ☐ Psychologist
☐ Registered Social Worker ☐ Registered Practical Nurse

If Other, please specify: _____

***Diabetes Diagnosis:** *(Select One)*

☐ Type 1 ☐ Type 2 ☐ MODY
☐ Cystic Fibrosis related ☐ Neonatal ☐ Secondary diabetes
☐ Unspecified

If Other, please specify: _____

***Date of Diagnosis:** dd / mm /yyyy

INITIAL DIAGNOSIS

Please complete this section for clinical information related to the diagnosis event only.

At diabetes diagnosis did the patient experience the following?:

☐ DKA ☐ HHS ☐ Mixed DKA/HHS
☐ None ☐ Unknown

What was the HbA1C at the time of diagnosis?:
(result in %) _____

What was the serum glucose value?:
(result in mmol/L) _____

What was the pH level?: _____

What was the Bicarbonate level? _____

What was the serum osmolality value?:
(result in mOsm/kg) _____

Was the patient's diabetes autoantibodies test completed?
(Select One) ☐ Yes ☐ No ☐ Unknown

Anti-GAD status: *(Select One)* ☐ Positive ☐ Negative
☐ Inconclusive ☐ Unknown

Anti-Insulin Status: *(Select One)* ☐ Positive ☐ Negative
☐ Inconclusive ☐ Unknown

Anti-Islet Cell Status: *(Select One)* ☐ Positive ☐ Negative
☐ Inconclusive ☐ Unknown

Anti-Islet Cell Status Date: dd / mm /yyyy

DIABETES CLINIC VISIT

ANTHROPOMETRIC MEASUREMENTS

Height (cm) at this visit: _____

Weight (kg) at this visit: _____

Systolic Blood Pressure at visit: _____

Diastolic Blood Pressure at visit: _____

GLUCOSE MONITORING & GLYCEMIC CONTROL

Measured HbA1C for this visit: *(%)* _____

Date of measured HbA1C: _____

Method of HbA1C:

☐ Community Laboratory/External Lab

☐ Hospital Laboratory
**If yes, enter name of device* _____

☐ Point of Care Testing
**If yes, enter name of device* _____

Type of glucose monitoring device: *(Select One)*

☐ rtCGM ☐ IsCGM/FGM ☐ SMBG ☐ Other ☐ Unknown

RtCGM/isCGM/FGM usage % in the last 14 days:

☐ Less than 80% ☐ 80% to 85% ☐ 86% to 90%
☐ 91% to 95% ☐ 96% to 100% ☐ Unknown

If CGM/FGM use is <80%, no need to enter time in range questions below

What is the percentage of time in the last two weeks where the range is between 3.9 and 10.0mmol/L: *(%)* _____

What is the percentage of time in the last two weeks where the range is between 3.0 and 3.8mmol/L: *(%)* _____

What is the percentage of time in the last two weeks where the range is below 3.0mmol/L: *(%)* _____

What is the percentage of time in the last two weeks where the range is above 10.0mmol/L: *(%)* _____

The average sensor glucose in the last 14 days reported by CGM/FGM: *(mmol/L)* _____

The standard deviation reported in the last 14 days:
(mmol/L) _____

DIABETES REGIMEN

How is insulin being administered:
☐ Injection ☐ Pump ☐ Patient not on insulin

Injection frequency: *(Select One)*

☐ MDI ☐ Bid ☐ Tid ☐ Basal only ☐ Bolus only
☐ Premixed insulin (Premixed analogue or Premixed regular)

Type of pump: *(Select One)*

☐ Standalone pump ☐ Low glucose suspend (PLGS)
☐ Predicted low glucose suspend (PLGS)
☐ Automated insulin delivery (AID)
☐ DIY loop ☐ Other (please specify)

If Other, please specify: _____

Total Daily Insulin Dose (average over past 14 days): _____

Total Daily Basal Dose (average over past 14 days): _____

External barriers influencing ability to use MDI or insulin pump: *(Select One)*

☐ Inadequate supports in school ☐ Financial barriers
☐ Currently not meeting ADP criteria for insulin pump
☐ Pump start wait list ☐ Unsure ☐ Other ☐ None

Is the patient prescribed Biguanides?:
(Select One) ☐ Yes ☐ No ☐ Unknown

Is the patient prescribed a DPP-4 inhibitor?:
(Select One) ☐ Yes ☐ No ☐ Unknown

Is the patient prescribed a GLP-1 agonist?:
(Select One) ☐ Yes ☐ No ☐ Unknown

Is the patient prescribed a SGLT2 inhibitor?:
(Select One) ☐ Yes ☐ No ☐ Unknown

Is the patient prescribed an insulin secretagogue?:
(Select One) ☐ Yes ☐ No ☐ Unknown

Please list any other oral diabetes medication not listed above which the patient is taking: _____

ADVERSE EVENTS

Number of severe hypoglycemic episodes since last visit: ____

Was an ER visit associated with the severe hypoglycemic event: *(Select One)* ☐ Yes ☐ No ☐ Unknown

Number of Diabetic Ketoacidosis (DKA) episodes since last visit: _____

Number of hyperglycemic hyperosmolar syndrome (HHS) Episodes since last visit: _____

DIABETES-ASSOCIATED HEALTH CONDITIONS

AUTOIMMUNE CONDITIONS

Date of Thyroid test: dd / mm /yyyy

Thyroid Stimulating Hormone (TSH) level: _____

Does the patient have positive thyroid peroxidase antibodies: *(Select One)*

☐ Positive ☐ Negative ☐ Unknown ☐ Not tested

Does the patient have positive thyroid anti-thyroglobulin antibodies?: *(Select One)*

☐ Positive ☐ Negative ☐ Unknown ☐ Not tested

Indicate if the patient has autoimmune hypothyroidism:
(Select One) ☐ Yes-being monitored/not on Thyroxine
☐ Yes-on thyroxine ☐ No

Indicate if the patient has hyperthyroidism:
(Select One) ☐ Yes ☐ No ☐ Unknown

Was the patient screened for celiac disease for this visit?
(Select One) ☐ Yes ☐ No ☐ Unknown

Date of celiac disease screening: dd / mm /yyyy

Indicate if the patient has celiac disease:
(Select One) ☐ Yes ☐ No ☐ Unknown

Does the patient have autoimmune adrenal insufficiency (Addison's Disease)?: *(Select One)* ☐ Yes ☐ No ☐ Unknown

Date of autoimmune adrenal insufficiency (Addison's Disease) diagnosis: dd / mm /yyyy

COMORBID CONDITIONS

Indicate if the patient has metabolic dysfunction-associated steatotic liver disease (MASLD):
(Select One) ☐ Yes ☐ No ☐ Unknown

Date of metabolic dysfunction-associated steatotic liver disease (MASLD) diagnosis: _____

Indicate if the patient has Polycystic Ovary Syndrome (PCOS): *(Select One)* ☐ Yes ☐ No ☐ Unknown

Date of Polycystic Ovary Syndrome (PCOS) diagnosis:
dd / mm /yyyy

Indicate if the patient has Obstructive Sleep Apnea (OSA):
(Select One) ☐ Yes ☐ No ☐ Unknown

Date of Obstructive Sleep Apnea (OSA) diagnosis:
dd / mm /yyyy

DIABETES-ASSOCIATED COMPLICATIONS

Has retinopathy screening been performed in the last 12 months? *(Select One)* ☐ Yes ☐ No ☐ Unknown

Date of retinopathy screening: dd / mm /yyyy

Does the patient have Diabetic Retinopathy or Maculopathy? *(Select One)* ☐ Yes ☐ No ☐ Unknown

Date of Diabetic Retinopathy or Maculopathy Diagnosis:
dd / mm /yyyy

Date of last kidney function test: dd / mm /yyyy

Urine albumin creatinine ratio (ACR) result: _____

Urine albumin excretion rate (AER) result (mg/mmol): _____

Does the patient have persistent albuminuria? *(Select One)*
☐ Yes ☐ No ☐ Unknown

Is patient taking an antihypertensive medication?: *(Select One)*
☐ Yes ☐ No ☐ Unknown

Is the patient taking a lipid lowering agent: *(Select One)*
☐ Yes ☐ No ☐ Unknown

Date lipid test was completed: dd / mm /yyyy

Total cholesterol measure in mmol/L: _____

Triglycerides measured in mmol/L: _____

High density lipoproteins (HDL) measured in mmol/L: _____

Low density lipoproteins (LDL) measured in IU/L: _____

Non HDL-C in mmol/L: _____

Alanine aminotransferase (ALT) level measured in IU/L: _____

Date of ALT test: dd / mm /yyyy

Aspartate aminotransferase (AST) level measured in IU/L: _____

Date of AST test: dd / mm /yyyy

Was neuropathy screening performed at this visit: *(Select One)*
☐ Yes ☐ No ☐ Not applicable

MENTAL HEALTH

Mental health diagnosis: *(Select All That Apply)*

☐ Depression ☐ Anxiety

☐ Self-Injurious / Self-harm / Suicidal behaviors

☐ Diabetes distress ☐ Disordered eating

☐ Disruptive behavior disorder ☐ ADHD

☐ Other mental health diagnosis, please specify (free text)

☐ Prefer not to answer

If Other, please specify: _____

Psychological health treatment: *(Select All That Apply)*

☐ Internal diabetes mental health team (e.g., social worker, psychologist)

☐ Intern hospital-based mental health provider (e.g., therapist, psychologist, psychiatrist)

☐ External/community mental health provider (e.g., therapist, agency, psychologist, psychiatrist, primary care)

Was psychological screening completed?
(Select One) ☐ Yes ☐ No ☐ Unknown

Date of psychological screening: dd / mm /yyyy

Indicate what tool was used in the psychological screening:

_____

What were the psychological disorder screening actions?:
(Select All That Apply)

☐ None-no psychological concerns identified

☐ Internal referral diabetes mental health team (e.g., social worder, psychologist)

☐ Internal referral to hospital-based mental health provider (e.g., therapist, psychologist, psychiatrist)

☐ External referral to community mental health provider (e.g., therapist, agency, psychologist, psychiatrist, primary care)

☐ Referral to emergency department (e.g., inpatient psychiatric hospital evaluation)

☐ Other, please specify

If Other, please specify: _____

SOCIAL DETERMINANTS OF HEALTH (SDOH)

Does the patient have a primary care provider?
(Select One) ☐ Yes ☐ No ☐ Unknown

Is the patient eligible for government insurance?: *(Select One)*

☐ OHIP+ ☐ Ontario Disability Support Program (ODSP)
☐ Ontario Disability Support Program (ODSP) ☐ Others
☐ None ☐ Unknown

Does the patient have any additional supplemental or private health insurance?:
(Select One) ☐ Yes ☐ No ☐ Unknown

How is the patient paying for rtCGM/isCGM/FGM?:
(Select All That Apply)

☐ ACSD (Assistance for Children with Severe Disabilities)

☐ ADP (Assistive Devices Program)

☐ Government insurance (other)

☐ Private insurance ☐ Out of pocket

☐ Not applicable ☐ Unknown

Does the patient/family household experience difficulty paying for basic needs?: *(Select One)*

☐ Yes ☐ No ☐ Unknown ☐ Prefer not to answer

Is the patient rationing medications and or diabetes supplies (e.g., insulin, needles, pump, CGM...etc):
(Select One)

☐ Yes-rationing quarterly

☐ Yes-rationing monthly

☐ Yes-rationing weekly or more

☐ Prefer not to answer

☐ Unknown

☐ Never/not applicable

What language(s) does the patient / family feel most comfortable speaking with their health care provider?
(select all that apply):

☐ English (Canadian Official Language)

☐ French (Canadian Official Language)

☐ Albanian ☐ Amharic ☐ Arabic

☐ ASL (American Sign Language)

☐ Bengali ☐ Bulgarian ☐ Burmese ☐ Georgian

☐ Greek ☐ Cantonese ☐ Czech ☐ Dari

☐ Farsi ☐ Gujarati ☐ Hausa ☐ Hebrew

☐ Hindi ☐ Hungarian ☐ Italian ☐ Karen

☐ Korean ☐ Mandarin ☐ Nepali ☐ Pashto

☐ Polish ☐ Portuguese ☐ Punjabi ☐ Rohingya

☐ Romanian ☐ Russian ☐ Serbian ☐ Slovak

☐ Somali ☐ Spanish ☐ Swahili ☐ Turkish

☐ Twi ☐ Ukrainian ☐ Tagalog ☐ Tamil

☐ Thai ☐ Tibetan ☐ Tigrinya

☐ Taishanese/Toishanese ☐ Urdu

☐ Vietnamese ☐ Other language

☐ Unknown ☐ Prefer not to answer

Which of the following best describes the patient's racial group(s)? *(Select all that apply):*

- ☐ Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian, etc.)
- ☐ East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.)
- ☐ Latin American (Hispanic or Latin American descent)
- ☐ Middle Easter, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.)
- ☐ South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.)
- ☐ Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.)
- ☐ White (e.g., European descent)
- ☐ Another race category
- ☐ Unknown ☐ Prefer not to answer

Does the patient have or identify as having a disability? *(Select all that apply):*

☐ Physical disability ☐ Sensory disability (e.g., hearing, vision)
☐ Intellectual disability ☐ Learning disability
☐ Autism Spectrum Disorder (ASD)
☐ Non-ASD developmental disability
☐ None ☐ Other ☐ Unknown ☐ Prefer not to answer

Was the patient born in Canada? *(Select One)*

☐ Yes ☐ No ☐ Unknown ☐ Prefer not to answer

If no, when did they arrive?: *(Select One)*

☐ Less than 5 years ago ☐ 5 to 9 years ago
☐ 10 years ago or more ☐ Unknown ☐ Prefer not to answer

TRANSITION, TRANSFER AND MORTALITY

Referral to adult provider sent: *(Select One)*

☐ DEP ☐ Adult Endocrinologist ☐ General Internist
☐ Primary Health Care Provider
☐ Other adult services (specify)
☐ No ☐ Unknown

If Other, please specify: _____

Date of last PDEP visit prior to transition: dd / mm /yyyy

First visit date with adult diabetes provider: dd / mm /yyyy

TRANSFER

Type of service patient has been transferred to: *(Select One)*

☐ PDEP Ontario ☐ PDEP outside of Ontario

MORTALITY

Date of patient's death: dd / mm /yyyy

Cause of death: *(Select One)* ☐ DKA ☐ Hypoglycaemia
☐ Not diabetes related ☐ Unknown