# DIABETES REPORT (Applicant to complete)

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| **1. Name:** |  | **2. CAA Client No:** |  |
| **3. Postal Address:** |  | **4. Date of Birth:** |  |
| **5. Certificate(s) applied for:** Class 1 Class 2 Class 2 – No IFR Class 3 | | | |

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| **6. DIABETES HISTORY**  **a. Diabetes type:** Type 1Type 2 **b. Year of diagnosis**  **c. Current Management:**   (Please provide details below) | | | |
| **List here each medication and preparation taken (if any) to control your diabetes:, including dose and time .**  Any smoking in the past 12 months? Yes No. . | | | |
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| **7. Monitoring**  **a**. Glucose monitoring meter used (if any) How often (frequency)  **b.** Do you use a continuous glucose monitoring device (if any monitoring)? If Yes specify type:  **c.** When did you last see the following (if any)  Date: / /  Date: / /  Dietician General Practitioner  Date: / /  Date: / /  Diabetes NurseDiabetes Specialist  **If doing self- monitoring of blood sugars, please provide a complete print out of all self-monitoring downloaded readings and their analysis for the past one year. Flying days must be outlined.**  **8. Control of diabetes (answer if on treatment other than diet and / or Metformin):** In the past 12 months, did you have? | | | |
| Any episode or symptoms of low blood sugar (Please describe and include frequency, last episode date &). | Low blood sugar results <4.1 mmol/L with or without symptoms (please include date / time of low results & attach your log). | | Hospital admissions, or needed assistance for low blood sugar? (Please include date of last admission / attendance & supply summary). |
| **9. Complications or Symptoms:** Please indicate if there are symptoms or have been any change in the following: . | | | |
| Vision change: (please include date & how changed) | | Numbness, tingling or feet pain (please include date & type of  problem) | |
| 10. Any comments you wish to make? | | | |
| 10**. Applicant’s Declaration:** I confirm that all the information entered onto this form in response to questions 1 to 9 is true and complete .  **Applicant’s Signature:** To be signed in presence of examining doctor. Date: / / . | | | |

**DIABETES REPORT (ME to complete)** 

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| **1. Name:** |  | **2. CAA Client No.:** |  |

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| 11. EXAMINATION | |  |  |
| **a. Medication**  Diet Sulphonylurea  Glitazones Insulin  Metformin Other | | **b. Cardiovascular system** Yes No  Peripheral pulses present  Absence of Bruits  /  /  Blood Pressure (Standing)  Blood Pressure (Lying) | **c. Peripheral Nervous System** Yes No  Microfilament sensation (Feet)  Vibration sense (Feet)  Reflexes (Legs)  Evidence of Neuropathy (Hands) |
| **d. Weight and change since last GME** | | **e. Other relevant findings** | |
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| **12. ME check list of tests/investigations** | **Please provide copies of the following:** *For diabetic on**Sulphonylurea or Insulin or potentially hypoglycaemia inducing combination*  - Complete print out of all self-monitoring downloaded readings for the past 6 months  - Their statistical analysis  - Flying days must be outlined  *All diabetics:*  - HBA1c results since last GME  - Latest blood lipids, creatinine, eGFR, uric acid  - Latest urine albumin/ creatinine ration/ microalbumin (at least annually)  - Latest retinal photo screening result - unless already provided within past 2 years  - Latest specialist reports (if any) - diabetes specialist / clinic reports / cardiologist / other as relevant | | |

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| **13. SUMMARY – ME ASSESSMENT OF DIABETES MANAGEMENT and DISEASE RELATED RISKS** | | |
| **Management compliance**  Excellent  Good  Sub Optimal | **Control**  Excellent  Good  Sub Optimal | **Cardiovascular Risk**  Yes No  10% or more at 5 years  Target Organs Damage (microalbuminuria, retinopathy microvascular disease, eGFR <60)  Stress ECG (if any)  Date: / /  Full tracing and report to be provided |

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| **14. ME comments about stability of current management / risks associated with hypoglycemic episodes or end organ disease:** (Comments should include further action recommended.) |

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| **15.** **Print Examiner’s Name and Address**  Practice Stamp Preferred) | **16. Client’s ID** (if unknown to ME):Type of photo ID sighted, number and expiry date.  Client’s photographic ID sighted at the medical examination. |
| **17. Examiner’s Declaration:** I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly.  Date: / /  Date: / / Date: / /  Examiner signature |
| Telephone Number: |