# 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 PractitionerDate: / /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 NoPeripheral pulses presentAbsence of Bruits / /Blood Pressure (Standing)Blood Pressure (Lying) | **c. Peripheral Nervous System** Yes NoMicrofilament 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 No10% or more at 5 yearsTarget Organs Damage(microalbuminuria, retinopathymicrovascular 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: |