Initial Clinical Islet Transplant Application

Thank you for your interest in the Clinical Islet Transplant Program at the University of Alberta Hospitals. At this stage, we only require some initial information about you and your diabetes.

This initial application consists of seven (7) sections:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Your personal information.</td>
<td>Page 2</td>
</tr>
<tr>
<td>2</td>
<td>Are you a candidate for an islet transplant?</td>
<td>Page 3</td>
</tr>
<tr>
<td>3</td>
<td>Clarke hypoglycemia survey.</td>
<td>Page 4</td>
</tr>
<tr>
<td>4</td>
<td>My current diabetes management.</td>
<td>Page 5</td>
</tr>
<tr>
<td>5</td>
<td>Physician information, referral letter and blood work request + TB/Immunization Information Sheet.</td>
<td>Page 6-7</td>
</tr>
<tr>
<td>6</td>
<td>Instructions, Glucose Records &amp; Hypoglycemic Sheets for 4 weeks of your blood glucose readings.</td>
<td>Pages 8-18</td>
</tr>
<tr>
<td>7</td>
<td>Consent for Sharing of Health Information</td>
<td>Pages 19-20</td>
</tr>
<tr>
<td></td>
<td>Consent for the Sharing of Health Information Consent</td>
<td>Pages 21-23</td>
</tr>
<tr>
<td></td>
<td>2nd Consent for Sharing of Health Information and Consent Forms</td>
<td>Pages 24-27</td>
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</tbody>
</table>

Once you have completely filled out the application (sections 1-7) please send it to the Clinical Islet Transplant Program. Please ensure that your name is clearly printed on all documents and dated correctly.

What happens next? After we have reviewed your completed application, one of our team will contact you to ask you more detailed questions about your diabetes and general health.

Best wishes,

Dr Peter A Senior, Medical Director/Endocrinologist   Dr AM James Shapiro, Director/Surgeon

IMPORTANT NOTIFICATION

Alberta Health collects personal information about you and your health in order to determine your eligibility for our programs and services, and to provide you with treatment, health care and other health services. The collection is authorized by section 20 of the Health Information Act and our use of this information is limited by the Act. We will protect the confidentiality of this health information and your privacy as required by the Act. Whenever your information is used for other purposes allowed by the Act or disclosed to others as allowed by the Act, it will be done in the most anonymous fashion possible and only that information needed for the purpose will be used or disclosed.

If you have any questions about this collection and use of your health information please talk to one of the staff at the Clinical Islet Transplant Program.
### SECTION 1:
YOUR PERSONAL INFORMATION

Please fill in the information below as completely as possible:

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
<th>LAST NAME</th>
<th>GENDER</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Circle One)</td>
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</table>

<table>
<thead>
<tr>
<th>MAIDEN NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If applicable)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
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<table>
<thead>
<tr>
<th>Telephone #</th>
<th>Home:</th>
<th>Work:</th>
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<td>(     )</td>
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<table>
<thead>
<tr>
<th>Cell:</th>
<th>Other:</th>
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<tbody>
<tr>
<td>(     )</td>
<td>(     )</td>
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</table>

Have you been a resident of Alberta before:  
Yes  No  (Circle One)  
If Yes, please provide us with previous Alberta Health Care # or Address:  

<table>
<thead>
<tr>
<th>Email</th>
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<table>
<thead>
<tr>
<th>Birth Date</th>
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<tbody>
<tr>
<td>Day (dd):</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic Background (circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>Oriental</td>
</tr>
<tr>
<td>Asian Indian</td>
</tr>
<tr>
<td>Latin American</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td>cm / in (circle unit)</td>
<td>kg / lb (circle unit)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insulin Dose:</th>
<th>units per day (average total daily dose)</th>
</tr>
</thead>
</table>

How many times do you check your glucose readings a day:  
1 2 3 4 5 6 7 or _______ (circle or fill in the blank)  

<table>
<thead>
<tr>
<th>Marital Status</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Occupation:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Today’s Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day:</td>
</tr>
</tbody>
</table>
## SECTION 2: ARE YOU A CANDIDATE FOR AN ISLET TRANSPLANT?

**PATIENTS NAME:** _______________________________  
**DATE:** ____________________________

<table>
<thead>
<tr>
<th></th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you a resident of Canada?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>2. Are you over 18 years?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>3. Do you have type 1 diabetes?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>4. What year was your diabetes diagnosed?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>5. Have you needed insulin to control your blood sugars for most of the time since your diagnosis?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>6. Have you had difficulty controlling your blood sugars despite having tried 3 or more injections of insulin per day?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>7. Do you have frequent low blood sugars that often required the help of another person?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>8. Have you ever had cancer, leukemia or lymphoma?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>9. Have you had a heart attack or stroke within the past 6 months?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>10. Are you currently on kidney dialysis?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>11. Are you currently a cigarette smoker?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>12. Are you taking a steroid medication for any reason (with the exception of steroid-based inhalers, creams or lotions)?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>13. Are you currently taking any blood thinners (except aspirin)?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>14. Are you pregnant or do you wish to become pregnant in the future?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>15. Do you have a problem with alcohol or drugs?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>16. Do you have any ongoing serious infections?</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>
SECTION 3:
CLARKE HYPOGLYCEMIA SURVEY

<table>
<thead>
<tr>
<th>PATIENTS NAME:</th>
<th>DATE:</th>
<th>FOR OFFICE USE ONLY</th>
</tr>
</thead>
</table>

1. **Check Category that best describes you (check one only):**
   - I always have symptoms when my blood sugar is low.
   - I sometimes have symptoms when my blood sugar is low.
   - I no longer have symptoms when my blood sugar is low.

2. **Have you lost some of the symptoms that used to occur when your blood sugar was low?**
   - Yes
   - No

3. **In the past 6 months, how often have you had moderate hypoglycemic episodes?**
   (Episodes where you might feel confused, disoriented, or lethargic and were unable to treat yourself)
   - Never
   - Once or twice
   - Every other month
   - Once a month
   - More than once a month

4. **In the past year, how often have you had severe hypoglycemic episodes?**
   (Episodes where you were unconscious or had a seizure and needed glucagons or intravenous glucose)
   - 1 or more times
   - 0 times

5. **How often in the last month have you had readings less than 3.9 mmol/L with symptoms?**
   - Never
   - 2 – 3 times per week
   - 1 – 3 times per month
   - 1 time per week
   - Almost daily

6. **How often in the last month have you had readings less than 3.9 mmol/L without symptoms?**
   - Never
   - 2 – 3 times per week
   - 1 – 3 times per month
   - 1 time per week
   - Almost daily

7. **How low does your blood sugar need to go before you feel symptoms?**
   - 3.3 – 3.9 mmol/L
   - 2.8 – 3.2 mmol/L
   - 2.2 – 2.7 mmol/L
   - Less than 2.2 mmol/L

8. **To what extent can you tell by your symptoms that your blood sugar is low?**
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

TOTAL
SECTION 4:
My Current Diabetes Management

PATIENTS NAME: ___________________________  DATE: ________________________________

1. I am using the following types of insulin currently:  
   Choose all that apply  
   □ Levemir or Lantus  
   □ NPH or Humulin N  
   □ Novorapid or Humalog or Apidra  
   □ Toronto or Humulin R  
   □ Other (Please specify): ________________________

2. I check my blood glucose:  
   □ Only if I feel unwell  
   □ 1-2 times/day  
   □ 3-4 times/day  
   □ More than 4 times/day

3. I inject insulin:  
   □ Whenever I remember or feel unwell  
   □ 1-2 times/day  
   □ 3-4 times/day  
   □ More than 4 times/day

4. I adjust my short-acting insulin according to:  
   Check all that apply  
   □ My blood glucose before eating by estimation  
   □ My blood glucose before eating by a scale I follow  
   □ My blood glucose before eating based on a correction factor  
   □ What I am going to eat by carbohydrate counting  
   □ What I am going to eat by portion size  
   □ What I am going to eat by guesstimating  
   □ What I am going to do  
   □ I never adjust my short-acting insulin-I just give what I have been told to.  
   □ I don’t use any short-acting insulin.  
   □ Other (please specify): ________________________________

5. Please write down your usual insulin regimen below with your specific doses:  
   (Write down your sliding scale, or your insulin:carbohydrate ratio and correction factor if you use these).
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
SECTION 5:
PHYSICIAN INFORMATION, REFERRAL AND
BLOOD WORK REQUISITIONS

PATIENTS NAME: ____________________  DATE: ________________________

Please fill in as much information below as possible and send this sheet back to us.

<table>
<thead>
<tr>
<th>YOUR FAMILY PHYSICIAN:</th>
<th>Full Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Postal Code:</td>
<td></td>
</tr>
<tr>
<td>Phone: ( ) -</td>
<td>Fax: ( ) -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YOUR DIABETES SPECIALIST:</th>
<th>Full Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Postal Code:</td>
<td></td>
</tr>
<tr>
<td>Phone: ( ) -</td>
<td>Fax: ( ) -</td>
</tr>
</tbody>
</table>

NOTE: If you have a diabetes specialist that you see regularly, a referral letter supporting you for an islet transplant may help us determine your suitability for a transplant.

Please take the attached requisitions to your local lab. We need the following blood work completed as part of your application:

**NOTE:** Please fill in any area that has an * beside it on the requisitions.

► Serum Creatinine
► Urine Random – Microalbumin: Creatinine (UALBR)
► HbA1c
► Blood Type
► TB & Immunization Update (Serology) –
  • HBs Ab (Immunity) See next page for info.
  • Measles IgG, Mumps IgG, Rubella IgG. See next page for info.

NOTE: If you are a patient from outside of Alberta, you may have to go to your family doctor/diabetes specialists to have the above blood work completed as some laboratories do not take our local requisitions.

Please fax 780.407.3850 or mail the blood work results to the address below.

If you have any questions or concerns, you can reach a University of Alberta Islet Transplant Coordinator at 780.407.1501 (leave message only).
TB & IMMUNIZATION UPDATE

COMMUNITY HEALTH UNIT (OR FAMILY DOCTOR)

Dear Sir/Madam:

As part of the assessment for possible islet transplantation, this patient requires a number of assessments for communicable diseases:

1. TUBERCULIN SKIN TEST:

   Please administer 5tu ppd. When you read the skin test after 48-72 hours, we require a fax documenting the result.

2. IMMUNIZATION HISTORY REVIEW & UPDATE:

   The Clinical Islet Transplant program follows the Alberta Immunization Manual. For out of province patients we recommend the use of the Alberta guidelines however you may defer to your own provincial guidelines if needed. Please review and update this patient’s immunizations ASAP as updating vaccinations may cause significant delays to transplant assessment.

   Please ensure the hepatitis B serology has been evaluated. We request that this person be vaccinated with dialysis strength 40 µg Recombivax HB as the recommended vaccine. Schedule of immunization is at 0, 1 and 6 months. The Islet program will arrange for hepatitis B antibody testing after their third vaccination.

   Please ensure MMR serology has been evaluated. If this person does not have positive antibodies (which indicate immunity due to either vaccination or prior exposure), we request that this person be vaccinated with one dose of the MMR Vaccine. Further serology testing and interpretation will be completed by Islet Transplant Program if patient is accepted as a candidate for Islet Transplant.

   Please forward a copy of the historical (if available) and updated Immunization Summary to our office after each patient visit.

Thank you for your assistance. If you have any concerns, please contact our office at 780-407-3571.

ALL CORRESPONDENCE CAN BE FAXED TO 780-407-3850.
SECTION 6:
4 WEEKS OF BLOOD GLUCOSE MONITORING RECORDS
AND HYPOGLYCEMIC SHEETS

As part of your application we will need you to send us at least 4 weeks of blood glucose records filled out completely.

Your application will not be processed until we receive these records.

The glucose monitoring record is important to:
   1. Assess your diabetes control.
   2. Assess your suitability for islet transplant.
   3. Help you achieve better diabetes control.

Please complete the records in as much detail as possible. The more information the better.

Instructions for completing the glucose monitoring records:

VERY IMPORTANT:

✓ Please write down your blood glucose results a minimum of 4 times/day and preferably at least 7 times/day for 4 weeks. We need you to write down your readings as well as your symptoms with the attached forms included.

✓ Please make sure that you calculate your total amount of daily insulin in units and write it in the space provided.

✓ Finally, please mark your weight down at least one time in the space provided per page.

Please DO NOT send in your printed off glucometer readings!

   ● The ideal times to check your blood would be in the morning when you wake up, before lunch, before supper, at bedtime and 2 hours after each meal.

Whenever your blood sugar is less than 3 mmol/L, please let us know about your symptoms and whether you needed help to recognize or treat these lows by filling in the appropriate check boxed in the hypoglycemia comments section. A list of neuroglycopenic and autonomic symptoms is provided on the bottom of each page for your reference. You may also describe these hypoglycemia episodes in greater detail if you wish in the other comments section, the back of the page or on an additional paper.

This is a key part of the applications. If you would be so kind as to collect these going forward over the next 4 weeks, it would be much appreciated. If you can give us any information about what symptoms you felt any time your glucose was low that would be very helpful. When you have completed the blood sugar readings, please send the completed sheets to the Islet Transplant Office at the address listed below.

NOTE: If needed, please make photocopies of the “Blood Glucose Monitoring Sheets” so that you can record 4 weeks of readings.

Thank you.
BLOOD GLUCOSE MONITORING RECORDS

PATIENT NAME: __________________________________

DATE: (DD/MMM/YYYY)  WEIGHT: (Kg/Lbs)  TOTAL DAILY INSULIN DOSE: (Units)

<table>
<thead>
<tr>
<th>Time</th>
<th>0100</th>
<th>0200</th>
<th>0300</th>
<th>0400</th>
<th>0500</th>
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<th>0800</th>
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<th>2100</th>
<th>2200</th>
<th>2300</th>
<th>2400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
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<tr>
<td>Insulin taken</td>
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</tr>
<tr>
<td>Food/Activity Comments</td>
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</tbody>
</table>

Hypoglycemia Comments

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

#1  #2  #3  #4

NEURO
Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Difficulty concentrating
- Difficulty speaking
- Weakness
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

AUTO
Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling
### BLOOD GLUCOSE MONITORING RECORDS

**PATIENT NAME:** ____________________________________________

<table>
<thead>
<tr>
<th>DATE: (DD/MMM/YYYY)</th>
<th>WEIGHT: (Kg/Lbs)</th>
<th>TOTAL DAILY INSULIN DOSE: (Units)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 0100 0200 0300 0400 0500 0600 0700 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800 1900 2000 2100 2200 2300 2400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose taken</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food/Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hypoglycemia Comments**

| Time 0100 0200 0300 0400 0500 0600 0700 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800 1900 2000 2100 2200 2300 2400 |
| Glucose taken        |                  |                                  |
| Food/Activity        |                  |                                  |
| Comments             |                  |                                  |

**Hypoglycemia Comments**

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

---

**DATE:** (DD/MMM/YYYY)  
**TOTAL DAILY INSULIN DOSE:** (Units)

Time 0100 0200 0300 0400 0500 0600 0700 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800 1900 2000 2100 2200 2300 2400

**Glucose taken**

**Food/Activity Comments**

**Hypoglycemia Comments**

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

---

**DATE:** (DD/MMM/YYYY)  
**TOTAL DAILY INSULIN DOSE:** (Units)

Time 0100 0200 0300 0400 0500 0600 0700 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800 1900 2000 2100 2200 2300 2400

**Glucose taken**

**Food/Activity Comments**

**Hypoglycemia Comments**

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

---

**NEURO**

Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Difficulty concentrating
- Difficulty speaking
- Weakness
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

**AUTO**

Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling
# BLOOD GLUCOSE MONITORING RECORDS

**PATIENT NAME:** __________________________________

**DATE:** (DD/MMM/YYYY)  

| Time | 0100 | 0200 | 0300 | 0400 | 0500 | 0600 | 0700 | 0800 | 0900 | 1000 | 1100 | 1200 | 1300 | 1400 | 1500 | 1600 | 1700 | 1800 | 1900 | 2000 | 2100 | 2200 | 2300 | 2400 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Glucose | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insulin taken | | | | | | | | | | | | | | | | | | | | | | | | | |

**WEIGHT:** (Kg/Lbs)  

**TOTAL DAILY INSULIN DOSE:** (Units)

### Food/Activity Comments

| Time | 0100 | 0200 | 0300 | 0400 | 0500 | 0600 | 0700 | 0800 | 0900 | 1000 | 1100 | 1200 | 1300 | 1400 | 1500 | 1600 | 1700 | 1800 | 1900 | 2000 | 2100 | 2200 | 2300 | 2400 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Glucose | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insulin taken | | | | | | | | | | | | | | | | | | | | | | | | | |

### Hypoglycemia Comments

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

**DATE:** (DD/MMM/YYYY)  

**TOTAL DAILY INSULIN DOSE:** (Units)

### Food/Activity Comments

| Time | 0100 | 0200 | 0300 | 0400 | 0500 | 0600 | 0700 | 0800 | 0900 | 1000 | 1100 | 1200 | 1300 | 1400 | 1500 | 1600 | 1700 | 1800 | 1900 | 2000 | 2100 | 2200 | 2300 | 2400 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Glucose | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insulin taken | | | | | | | | | | | | | | | | | | | | | | | | | |

### Hypoglycemia Comments

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

**DATE:** (DD/MMM/YYYY)  

**TOTAL DAILY INSULIN DOSE:** (Units)

### Food/Activity Comments

| Time | 0100 | 0200 | 0300 | 0400 | 0500 | 0600 | 0700 | 0800 | 0900 | 1000 | 1100 | 1200 | 1300 | 1400 | 1500 | 1600 | 1700 | 1800 | 1900 | 2000 | 2100 | 2200 | 2300 | 2400 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Glucose | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insulin taken | | | | | | | | | | | | | | | | | | | | | | | | | |

### Hypoglycemia Comments

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

**NEURO**  
Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Difficulty concentrating
- Difficulty speaking
- Weakness
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

**AUTO**  
Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling
## Blood Glucose Monitoring Records

**Patient Name:**

### Date: (DD/MMM/YYYY)  
**Weight:** (Kg/Lbs)  
**Total Daily Insulin Dose:** (Units)

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### Hypoglycemia Comments

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

#### Hypoglycemia Comments

- #1
- #2
- #3
- #4

#### Other comments

### Date: (DD/MMM/YYYY)  
**Weight:** (Kg/Lbs)  
**Total Daily Insulin Dose:** (Units)

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### Hypoglycemia Comments

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

#### Hypoglycemia Comments

- #1
- #2
- #3
- #4

#### Other comments

### Date: (DD/MMM/YYYY)  
**Weight:** (Kg/Lbs)  
**Total Daily Insulin Dose:** (Units)

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### Hypoglycemia Comments

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

- Seizure
- No symptoms
- Confusion
- Neuro (see below)
- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

#### Hypoglycemia Comments

- #1
- #2
- #3
- #4

#### Other comments

---

**Neuro**

Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Difficulty concentrating
- Difficulty speaking
- Weakness
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

**Auto**

Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling
# Blood Glucose Monitoring Records

**Patient Name:**

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<th>Date: (DD/MMM/YYYY)</th>
<th>Weight: (Kg/Lbs)</th>
<th>Total Daily Insulin Dose: (Units)</th>
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**Hypoglycemia Comments**

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**Date:** (DD/MMM/YYYY)

**Total Daily Insulin Dose:** (Units)

| Time               | 0100 0200 0300 0400 0500 0600 0700 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800 1900 2000 2100 2200 2300 2400 |
|---------------------|------------------|----------------------------------|
| Glucose taken       |                  |                                  |
| Insulin taken       |                  |                                  |
| Food/Activity       |                  |                                  |
| Comments            |                  |                                  |

**Hypoglycemia Comments**

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**Date:** (DD/MMM/YYYY)

**Total Daily Insulin Dose:** (Units)

| Time               | 0100 0200 0300 0400 0500 0600 0700 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800 1900 2000 2100 2200 2300 2400 |
|---------------------|------------------|----------------------------------|
| Glucose taken       |                  |                                  |
| Insulin taken       |                  |                                  |
| Food/Activity       |                  |                                  |
| Comments            |                  |                                  |

**Hypoglycemia Comments**

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**Neuro**

Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Difficulty concentrating
- Difficulty speaking
- Weakness
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

**Auto**

Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling
## BLOOD GLUCOSE MONITORING RECORDS

**PATIENT NAME:**

### DATE: (DD/MMM/YYYY) | WEIGHT: (Kg/Lbs) | TOTAL DAILY INSULIN DOSE: (Units)

<table>
<thead>
<tr>
<th>Glucose</th>
<th>Insulin taken</th>
<th>Food/Activity Comments</th>
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<tbody>
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### Hypoglycemia Comments

- **Seizure**
- **No symptoms**
- **Confusion**
- **Neuro (see below)**
- **Auto (see below)**

Check all that apply for each episode of hypoglycemia < 3 mmol/L:

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### Neurological Symptoms

- **Change in behavior**
- **Drowsiness**
- **Visual blurring**
- **Tiredness**
- **Dizziness**

### Autonomic Symptoms

- **Trembling**
- **Palpitations (heart pounding)**
- **Sweating**
- **Anxiety**

**NEURO**

Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

**AUTO**

Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety

Hunger
Nausea
Tingling
# BLOOD GLUCOSE MONITORING RECORDS

**PATIENT NAME:**

### DATE: (DD/MMM/YYYY)  WEIGHT: (Kg/Lbs)  TOTAL DAILY INSULIN DOSE: (Units)

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### Food/Activity Comments

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- Auto (see below)
- Help to recognize
- Help to treat
- Other comments

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**NEURO**

Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Difficulty concentrating
- Difficulty speaking
- Weakness
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

**AUTO**

Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling

---

15
# BLOOD GLUCOSE MONITORING RECORDS

**PATIENT NAME:**

<table>
<thead>
<tr>
<th>DATE: <strong>(DD/MMM/YYYY)</strong></th>
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**NEURO**

Check the “Neuro” box if you have 1 or more of the following:

- Change in behavior
- Difficulty concentrating
- Difficulty speaking
- Weakness
- Drowsiness
- Visual blurring
- Tiredness
- Dizziness

**AUTO**

Check the “Auto” box if you have 1 or more of the following:

- Trembling
- Palpitations (heart pounding)
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling
**BLOOD GLUCOSE MONITORING RECORDS**

**PATIENT NAME:** __________________________________

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**Hypoglycemia Comments**

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- Tiredness
- Dizziness
- Trembling
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- Sweating
- Anxiety

**Check the “Auto” box if you have 1 or more of the following:**

- Hunger
- Nausea
- Tingling
SECTION 7
CONSENT FOR SHARING OF HEALTH INFORMATION

Dear Patient,

The Health Information Act – the law in Alberta that controls the collection, use and sharing of health information – requires that we have your consent before we share your health information with anyone not directly involved in your care. We are writing to you because there may be times when we need to discuss your health information with your chosen support person. We may also need to leave you messages when we cannot reach you by phone. We may need to contact the police for assistance if we are experiencing difficulty locating you for your transplant. Lastly, we need to include your name on the national transplant waiting list, which allows transplant centres across Canada to properly allocate donated organs. All of these require your consent. Attached is an Information Sheet outlining the risks and benefits of consent and the Consent for Sharing of Health Information. We would also like to inform you that our patient records are electronic, and that we receive an automatic download of much of your health information that we do not specifically request. This electronic record is properly secured and we do not inappropriately use or disclose any of this additional information.

Instructions:

- **Information Sheet**: Please read this.
- **Consent for Sharing of Health Information**: Print your full legal name in the space provided at the top of the form.
- **Consent for Authorization of Personal Representative**: Enter the name of your support person, phone number(s) and address in the spaces provided. This will not change your medical care. It simply allows us to release information to your support person when needed.
- **Consent for Messages**: Choose whether you will allow us to leave messages by checking one of the boxes. This allows us to leave you messages by any of the methods listed if we cannot reach you personally.
- **Consent for Disclosure to Police**: In most cases the information given to police will be that you are waiting for a transplant and that we cannot find you. We will tell them that it is a medical emergency and that we must find you immediately. We will probably give them your address. We will only do this if every other way of contacting you has failed. Choose whether you will allow us to contact the police by checking one of the boxes.
- **Consent for Inclusion on the National Transplant Waiting List**: Choose whether you will allow us to submit your name to the national transplant waiting list by checking one of the boxes. This is necessary to allow transplant centres across Canada to properly allocate donated organs.
- **Date the form on the last page and sign on the line “Signature of Patient/Resident/Client or Authorized Representative”**: Print your name on the line to the right and have a witness do the same underneath your signature in the spaces provided. A witness may be anyone over the age of 18 years. It does not need to be a health care worker. You should generally not include an expiry date unless you have a specific reason for doing so.

Complete these forms and keep the 2nd copy, which is provided, of the Consent for Sharing of Health Information for your records. Please mail in the original copy to the Clinical Islet Transplant Program. You also may keep the Information Sheet.

If you have any questions, please phone your transplant coordinator. For more information on the Health Information Act, contact Alberta Health Services’ Information Access and Privacy Office at (780) 735-0143.

For patients under the age of 18 years, if the patient is able to understand the consequences of this consent, then the patient must sign the form. If the patient is not able to fully understand, then the patient’s parent or legal guardian must sign the form. Please call your transplant coordinator if you are unsure who should sign the consent.

Thank you for your assistance.
Consent for the Sharing of Health Information
Information Sheet

Consent for Authorization of Personal Representative

Benefits of Consent: The transplant process is long and demanding. You receive a lot of information that is difficult to understand and remember. Your support person will be more helpful if you share your health information with him or her.

Risks of Consent: We cannot control what your support person does with the information we share with him or her.

Consent for Messages

Benefits of Consent: We will be able to give you important health information quickly, even when we cannot reach you personally. You may not get important information as quickly as needed if you do not consent. There may be serious consequences depending on the nature of the information.

Risks of Consent: If we leave a message on an answering machine, another person may hear it. If we leave a message with a family member, we cannot control what they do with it.

Consent for Disclosure to Police

Benefits of Consent: The police will help us find you for your transplant when we cannot reach you ourselves. If you choose not to consent and we cannot reach you, the organ will be given to another recipient. You will then continue to wait for an organ.

Risks of Consent: Your health information will be shared with the police. We cannot control what they do with the information.

Consent for Inclusion on the National Transplant Waiting List

Benefits of Consent: The national transplant waiting list ensures that organs are allocated appropriately across Canada.

Risks of Consent: Your health information will be shared with all transplant centres in Canada. We cannot control what they do with the information.
CONSENT FOR THE SHARING OF HEALTH INFORMATION

I, _________________________________________, hereby authorize Alberta Health Services, Transplant Services to disclose health information specified below in accordance with section 34 of the Health Information Act.

CONSENT FOR AUTHORIZATION OF PERSONAL REPRESENTATIVE

I understand that I require a family member, friend or interpreter to act as a support person during the process of evaluation, waiting for and receiving an organ transplant. I further understand that it is necessary for that person to be aware of my health situation and conditions that may affect that situation.

I therefore authorize Alberta Health Services, Transplant Services, to provide to _______________________________________________________
whose telephone number(s) are (_____) ___________________________
and who lives at _______________________________________________________
the following individually identifying health information:

- Any information required to enable proper treatment and care during the assessment, waiting and post transplant phases of this process.
- Any information that my case coordinator believes the person needs to act in this support role.
- Access to my health record in order that the person may help me to understand the requirements of the transplant process.
- Information needed to ensure that I attend appointments and meetings related to my assessment treatment and care.
CONSENT FOR MESSAGES

I understand that the transplant team is not always able to speak to me directly and may have important medical information that needs to be relayed to me. I understand that it may be necessary at times for the transplant team to leave messages on my home or work voice mail or with a family member.

In order to convey health information to me in a timely manner, I

☐ authorize
☐ do not authorize

Alberta Health Services, Transplant Services, to leave messages containing individually identifying health information for me on my home voice mail, my mobile phone voice mail, my office voice mail, or with a family member at my home phone number.

CONSENT FOR DISCLOSURE TO POLICE

I understand that in the event the transplant team cannot contact me when an organ becomes available, it may be necessary to involve the police in order to determine my whereabouts. In the event that the police are called to locate me, they will only be given registration information and advised that I am a transplant patient.

I therefore

☐ authorize
☐ do not authorize

the disclosure of individually identifying health information to the appropriate police service by Alberta Health Services, Transplant Services in the event that I cannot be contacted by regular means when called for transplant.

CONSENT FOR INCLUSION ON THE NATIONAL TRANSPLANT WAITING LIST

I understand that the transplant program will include my name on the national transplant waiting list, which allows Canadian transplant centres to allocate organs to the appropriate patients on a national basis.

I therefore

☐ authorize
☐ do not authorize

the disclosure of individually identifying health information to the national transplant waiting list.
I understand why I have been asked to disclose my health information, and am aware of the risks or benefits of consenting, or refusing consent, to the disclosure of this information. I understand that I may revoke this consent at any time.

Dated this of, _____ of ____________, ________
(day) (month) (year)

Expiry date (if any) of, _____ of ____________, ________
(day) (month) (year)

__________________________________
Signature of Patient/Resident/Client or Authorized Representative

__________________________________
Printed Name of Patient/Resident/Client or Authorized Representative

__________________________________
Address of Patient/Resident/Client or Authorized Representative

__________________________________
Phone Number with Area Code

__________________________________
Signature of Witness

__________________________________
Printed Name of Witness
Consent for Authorization of Personal Representative

Benefits of Consent: The transplant process is long and demanding. You receive a lot of information that is difficult to understand and remember. Your support person will be more helpful if you share your health information with him or her.

Risks of Consent: We cannot control what your support person does with the information we share with him or her.

Consent for Messages

Benefits of Consent: We will be able to give you important health information quickly, even when we cannot reach you personally. You may not get important information as quickly as needed if you do not consent. There may be serious consequences depending on the nature of the information.

Risks of Consent: If we leave a message on an answering machine, another person may hear it. If we leave a message with a family member, we cannot control what they do with it.

Consent for Disclosure to Police

Benefits of Consent: The police will help us find you for your transplant when we cannot reach you ourselves. If you choose not to consent and we cannot reach you, the organ will be given to another recipient. You will then continue to wait for an organ.

Risks of Consent: Your health information will be shared with the police. We cannot control what they do with the information.

Consent for Inclusion on the National Transplant Waiting List

Benefits of Consent: The national transplant waiting list ensures that organs are allocated appropriately across Canada.

Risks of Consent: Your health information will be shared with all transplant centres in Canada. We cannot control what they do with the information.
CONSENT FOR THE SHARING OF HEALTH INFORMATION

I, _________________________________________, hereby authorize Alberta Health Services, Transplant Services to disclose health information specified below in accordance with section 34 of the Health Information Act.

CONSENT FOR AUTHORIZATION OF PERSONAL REPRESENTATIVE

I understand that I require a family member, friend or interpreter to act as a support person during the process of evaluation, waiting for and receiving an organ transplant. I further understand that it is necessary for that person to be aware of my health situation and conditions that may affect that situation.

I therefore authorize Alberta Health Services, Transplant Services,

to provide to __________________________________________________________
whose telephone number(s) are (________) __________________________________
and who lives at _______________________________________________________

the following individually identifying health information:

- Any information required to enable proper treatment and care during the assessment, waiting and post transplant phases of this process.

- Any information that my case coordinator believes the person needs to act in this support role.

- Access to my health record in order that the person may help me to understand the requirements of the transplant process.

- Information needed to ensure that I attend appointments and meetings related to my assessment treatment and care.
**CONSENT FOR MESSAGES**

I understand that the transplant team is not always able to speak to me directly and may have important medical information that needs to be relayed to me. I understand that it may be necessary at times for the transplant team to leave messages on my home or work voice mail or with a family member.

In order to convey health information to me in a timely manner, I

- authorize
- do not authorize

Alberta Health Services, Transplant Services, to leave messages containing individually identifying health information for me on my home voice mail, my mobile phone voice mail, my office voice mail, or with a family member at my home phone number.

**CONSENT FOR DISCLOSURE TO POLICE**

I understand that in the event the transplant team cannot contact me when an organ becomes available, it may be necessary to involve the police in order to determine my whereabouts. In the event that the police are called to locate me, they will only be given registration information and advised that I am a transplant patient.

I therefore

- authorize
- do not authorize

the disclosure of individually identifying health information to the appropriate police service by Alberta Health Services, Transplant Services in the event that I cannot be contacted by regular means when called for transplant.

**CONSENT FOR INCLUSION ON THE NATIONAL TRANSPLANT WAITING LIST**

I understand that the transplant program will include my name on the national transplant waiting list, which allows Canadian transplant centres to allocate organs to the appropriate patients on a national basis.

I therefore

- authorize
- do not authorize

the disclosure of individually identifying health information to the national transplant waiting list.
I understand why I have been asked to disclose my health information, and am aware of the risks or benefits of consenting, or refusing consent, to the disclosure of this information. I understand that I may revoke this consent at any time.

Dated this of, _____ of __________, ________
(day) (month) (year)

Expiry date (if any) of , _____ of __________, ________
(day) (month) (year)

Signature of Patient/Resident/Client or Authorized Representative

Printed Name of Patient/Resident/Client or Authorized Representative

Address of Patient/Resident/Client or Authorized Representative

Phone Number with Area Code

Signature of Witness

Printed Name of Witness