Insulin Discharge Information: Patients who require community nurse input

Write in black ink
Mark tick boxes as directed
Sign and date all entries

Hospital: ____________________________________________________________
Ward: ______________________________________________________________
Date of Discharge: ____________________________________________________

To be completed by prescriber prior to discharge

<table>
<thead>
<tr>
<th>Subcutaneous Insulin (+ brand)</th>
<th>Device</th>
<th>Dose and time</th>
<th>New? (Y/N)</th>
<th>Prescriber signature + name (PRINT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre breakfast</td>
<td>units</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Pre lunch</td>
<td>units</td>
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<td></td>
<td></td>
<td>Pre evening meal</td>
<td>units</td>
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<td>Pre bedtime</td>
<td>units</td>
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<td></td>
<td></td>
<td>Pre bedtime</td>
<td>units</td>
<td></td>
</tr>
</tbody>
</table>

Date: ________________

Type of diabetes: ________________________________
Current HbA1C result (if known): __________________

Any changes to insulin whilst in hospital? Please document changes + reasons.

Completed by (sign and print): __________________________________________ Designation: ________________________________

To be completed by nurse on ward prior to discharge

Has a diabetes specialist nurse been involved in the patient’s care during this admission? Yes / No

Wansbeck General Hospital: 01670 529368       Hexham General Hospital: 01434 655095
North Tyneside General Hospital: 0191 293 4085       NSEC H: 0191 607 2642

Why is community nurse support required? (please circle)

Patient unable to self-administer / short term support / other: ________________________________

Date / time of last dose on ward: ________________________________
Insulin name: ________________________________
Dose given: ________________________________ units

Does the patient have sufficient quantities of:

Yes  No  NA

Insulin
Insulin device (if used)
BD SafetyGlide Insulin Syringes (if req)
Needles (BD AutoShield Duo)
Glucose meter (if provided by DSN)

If necessary, obtain supply prior to discharge

N.B.: A copy of this form must be faxed to the district nurses

Completed by (sign and print): __________________________________________ Designation: ________________________________

Contact number of ward: ________________________________ Date: ________________

Authors Amy Bradley, Jacqui Ballantyne, Janet Kelly, Sue Robson
Version 2 – Insulin Discharge Information. Updated: January 2018, Review Date: January 2020