

# ABCD Nationwide FreeStyle Libre Audit

## Pre-FreeStyle Libre Information Collection Form

Hospital Name

Centre ID

Date

 /  / 

Name of Clinician

Email

**AFFIX PATIENT LABEL HERE**

NHS Number

Forename

Surname

Date of Birth

 /  / 

Gender

Male

Female

### Ethnicity

White	<input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other white background
Asian or Asian British	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background
Black or Black British	<input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other
Mixed	<input type="checkbox"/> White and black Caribbean <input type="checkbox"/> White Asian <input type="checkbox"/> Any other mixed background group
Other ethnic group	<input type="checkbox"/> Chinese <input type="checkbox"/> Any other group <input type="checkbox"/> Not stated

### Driving status

<input type="checkbox"/> Does not drive	<input type="checkbox"/> Standard licence
<input type="checkbox"/> Taxi licence	<input type="checkbox"/> HGV licence

Height (metres)

Weight(kg)

Body Mass Index

Duration of diabetes

<input type="text"/>	years
<input type="text"/>	months

### Type of diabetes

<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	<input type="checkbox"/> MODY	
<b>During pregnancy:</b>	<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Type 1 diabetes during pregnancy	<input type="checkbox"/> Type 2 diabetes during pregnancy
<input type="checkbox"/> Other (please specify)	<input type="text"/>		

### PATIENT USE OF FREESTYLE LIBRE

Is this assessment:

<input type="checkbox"/> Recorded prior to commencing FreeStyle Libre?	<input type="checkbox"/> Recorded retrospectively – i.e. after FreeStyle Libre started?
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What is the date of FreeStyle Libre start? (best estimate if uncertain)

 /  / 

If not, intended date of initiation of FreeStyle Libre

 /  / 

Use of a CGM within the last 6 month before starting FreeStyle Libre?

 Yes  No

Funding of FreeStyle Libre

 NHS funded  Non-NHS funded

If non-NHS funded please give details

<input type="checkbox"/> Professional recommendation	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Patient initiated	<input type="text"/>

**Reason for starting FreeStyle Libre (please tick as many boxes as apply)**

<input type="checkbox"/> High HbA1c	<input type="checkbox"/> Recurrent hospital admissions (>2 DKA or hypo per year)	Replacement of SMBG <input type="checkbox"/> ≥ 8 tests per day <input type="checkbox"/> < 8 tests per day
<input type="checkbox"/> Frequent hypoglycaemia	<input type="checkbox"/> Recently developed hypoglycaemic unawareness	<input type="checkbox"/> NICE criteria for insulin pump fulfilled, where successful trial might avoid insulin pump
<input type="checkbox"/> Fear of hypoglycaemia	<input type="checkbox"/> High glucose variability	<input type="checkbox"/> Unable to self monitor, need third party assistance
<input type="checkbox"/> Gastroparesis	<input type="checkbox"/> Patient choice	<input type="checkbox"/> Hemodialysis
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Pregnant (estimated date of delivery)    /    /	
<input type="checkbox"/> Psychosocial circumstance	<input type="checkbox"/> Previous self funder with HbA1c improvement	<input type="checkbox"/> Occupational circumstance
<input type="checkbox"/> Other diabetes complications (please specify)		
<input type="checkbox"/> Other reasons (please specify)		

**HAS THE PATIENT HAD STRUCTURED EDUCATION?**

Yes     Not as far as I am aware     Don't know

If yes, please specify

DAFNE     DESMOND/X-PERT     Other (please specify)    \_\_\_\_\_

Date of last training (best estimate if uncertain)    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**USE OF NHS RESOURCES BEFORE STARTING FREESTYLE LIBRE**

Answer for 12 MONTH period before starting Freestyle Libre.  
 If filling in retrospectively please fill in follow up form at the same visit.  
 For all questions extract data from records otherwise use best estimate where possible.

Average number of SMBG tests in the last 2 weeks    Average number per day    \_\_\_\_\_    Don't know   

In the year before starting FreeStyle Libre	Hyperglycaemia/DKA	Hypoglycaemia	Unclassifiable diabetes related	Other
Number of admissions	_____	_____	_____	_____
Date(s)	_____	_____	_____	_____
Number of paramedic call outs not resulting in admission	_____	_____	_____	_____
Date(s)	_____	_____	_____	_____

Number of hypoglycaemic episodes requiring third party assistance not resulting in paramedic call outs or admission    Number    \_\_\_\_\_    Date(s)    \_\_\_\_\_    Don't know   

**HYPOGLYCAEMIC AWARENESS BEFORE STARTING FREESTYLE LIBRE**

PLEASE DON'T ENTER RECOLLECTED INFORMATION. Only enter if information obtained prospectively or contemporaneous data present in patient records.

Assessment of awareness of hypoglycaemia (Gold Score). Does the patient know when hypos are commencing?

1                      2                      3                      4                      5                      6                      7

1 = Always aware, 7 = Never aware.

continued overleaf

### CAPILLARY BLOOD GLUCOSE MONITOR METER DOWNLOAD DATA BEFORE STARTING FREESTYLE LIBRE (IF AVAILABLE)

Number of days downloaded	Average tests per day	% of tests showing capillary blood glucose equal or < 3.9	% of tests showing capillary blood glucose equal or > 10.1 mmol/L	Tests <2.5mmol within past 14 days
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please add all available data even if you do not have it all.

### HbA1c TESTS DONE IN THE LAST 12 MONTHS BEFORE STARTING FREESTYLE LIBRE HbA1c tests after starting FreeStyle Libre to be captured on follow up form

Date of test:	<input type="text"/> / <input type="text"/> / <input type="text"/>	HbA1c	<input type="text"/>	mmol/mol
Date of test:	<input type="text"/> / <input type="text"/> / <input type="text"/>	HbA1c	<input type="text"/>	mmol/mol
Date of test:	<input type="text"/> / <input type="text"/> / <input type="text"/>	HbA1c	<input type="text"/>	mmol/mol
Date of test:	<input type="text"/> / <input type="text"/> / <input type="text"/>	HbA1c	<input type="text"/>	mmol/mol
Date of test:	<input type="text"/> / <input type="text"/> / <input type="text"/>	HbA1c	<input type="text"/>	mmol/mol
Date of test:	<input type="text"/> / <input type="text"/> / <input type="text"/>	HbA1c	<input type="text"/>	mmol/mol
Date of test:	<input type="text"/> / <input type="text"/> / <input type="text"/>	HbA1c	<input type="text"/>	mmol/mol

### MEDICATIONS

Metformin     Sulphonylureas     TZDs     GLP-1 agonists     DPP4 inhibitors     SGLT-inhibitors

Quick acting insulin     Basal insulin     Insulin mixtures     Basal bolus     Insulin pump

Total insulin dose units per day

Other medications which could affect glycaemic control

### DIABETES DISTRESS SCREENING SCALE

DO NOT ENTER RECOLLECTED INFORMATION. Only enter if information obtained prospectively or contemporaneous data present in patient records.

	Not A Problem	A Slight Problem	A Moderate Problem	Somewhat Serious Problem	A Serious Problem	A Very Serious Problem
1 Feeling overwhelmed by the demands of living with diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Feeling that I am often failing with my diabetes routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### OTHER PATIENT COMMENTS?

### OTHER HEALTHCARE PROFESSIONAL COMMENTS?