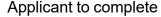
## Part 67 diabetes report Applicant to complete





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 ☐		
6. DIABETES HISTORY		
a. Diabetes type: Type 1  Type 2  b. Year of diagno	osis	
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. ☐		
7. Monitoring		
a. Glucose monitoring meter used (if any)  How often (frequency)		
<b>b.</b> Do you use a continuous glucose monitoring device (if any monitoring)? If Yes specify		
c. When did you last see the following (if any)		
Dietician Date: / / General Prac	ctitioner Date: / /	
Diabetes Nurse Date: / / Diabetes Spe	ecialist Date: / /	
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 t	the past 12 months, did you have?	
sugar (Please describe and include frequency, last episode date &).  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: / /	

## Part 67 diabetes report

ME to complete



1. Name:		2. CAA Client No.:
11. EXAMINATION  a. Medication  □ Diet □ Sulphonylurea □ Glitazones □ Insulin □ Metformin □ Other	b. Cardiovascular system Yes Peripheral pulses present Absence of Bruits  Blood Pressure (Standing)  /	No   C. Peripheral Nervous System   Yes   No   Microfilament sensation (Feet)
d. Weight and change since last GME	e. Other relevant findings	
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		
13. SUMMARY – ME ASSESSMENT OF DIABETES MANAGEMENT and DISEASE RELATED RISKS  Management compliance Control Cardiovascular Risk		
□ Excellent □ Good □ Sub Optimal	☐ Excellent ☐ Good ☐ Sub Optimal	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
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		
Telephone Number:	my examination completely and corr	