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 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. ☐

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

c. When did you last see the following (if any)

Dietician Date: / /

General Practitioner Date: / /

Diabetes Nurse Date: / /

Diabetes Specialist 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 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: / /

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	No
Peripheral pulses present	☐	☐
Absence of Bruits	☐	☐
Blood Pressure (Standing)	/	
Blood Pressure (Lying)	/	

c. Peripheral Nervous System	Yes	No
Microfilament sensation (Feet)	☐	☐
Vibration sense (Feet)	☐	☐
Reflexes (Legs)	☐	☐
Evidence of Neuropathy (Hands)	☐	☐

d. Weight and change since last GME

e. Other relevant findings

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

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	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

14. ME comments about stability of current management / risks associated with hypoglycemic episodes or end organ disease: (Comments should include further action recommended.)

15. Print Examiner's Name and Address
Practice Stamp Preferred)

Telephone Number:

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.

Examiner signature

Date: / /