

DIABETES CARE FLOW SHEET

This flow sheet indicates the minimum services to be provided in the continuing care of patients with diabetes according to recognized standards of care (i.e., American Diabetes Association). It is not intended to preclude more intensive evaluation and management where medically indicated.

Quarterly visits and tests	Year 1 200__				Year 2 200__				Year 3 200__			
	Qtr 1 Date	Qtr 2 Date	Qtr 3 Date	Qtr 4 Date	Qtr 1 Date	Qtr 2 Date	Qtr 3 Date	Qtr 4 Date	Qtr 1 Date	Qtr 2 Date	Qtr 3 Date	Qtr 4 Date
Blood Pressure (Goal <130/80 mm Hg)												
Weight (lbs.) (Every visit)												
Foot exam (annually or more often if high risk) (Does patient need a referral?)												
Assess diabetes control A1C (goal less than 7%) (Every 6 months if controlled) Review Blood Glucose Log?												
Hospitalizations/ER Visits?												

Yearly Testing	Date	Result	Date	Result	Date	Result
Dilated eye exam or retinal photo: (Does patient need referral?)						
Lipid Control:						
▪ LDL (goal less than 100 mg/dl)						
▪ HDL (goal greater than 45 mg/dl-men); (goal greater than 55 mg/dl for women)						
▪ Triglycerides (goal less than 150 mg/dl)						
Renal Function Tests:						
▪ Microalbumin (urine)						
If positive urine microalbumin or protein, ACE inhibitor prescribed?						
Immunizations:						
▪ Flu shot						
▪ Pneumonia shot						

Controllable risks (Discuss these risks with your patient)	Year 1 200__		Year 2 200__		Year 3 200__	
Recent severe hypo/hyperglycemia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Education in self-management?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nutrition counseling?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you use tobacco?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Advised smoking cessation program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
For women: Are you planning a pregnancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is OB referral needed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Name _____ DOB _____ ID# _____