

<b>Name:</b>		<b>PMP:</b>		
<b>DOB:</b>		<b>MR #:</b>		
<b>Type of Diabetes:</b> <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Other		<b>Date of diagnosis:</b>		
<b>Co-morbidities</b>		<b>Medication</b>		
<input type="checkbox"/> Hypertension <span style="margin-left: 150px;"><input type="checkbox"/> Dyslipidemia</span> <input type="checkbox"/> PAD <span style="margin-left: 150px;"><input type="checkbox"/> CAD</span> <input type="checkbox"/> Mental health dx <span style="margin-left: 150px;"><input type="checkbox"/> CKD</span> <input type="checkbox"/> Foot disease <span style="margin-left: 150px;"><input type="checkbox"/> PCOS</span> <input type="checkbox"/> Other: _____		Oral medication: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Insulin: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Home monitoring: <input type="checkbox"/> Yes <input type="checkbox"/> No _____		
<b>Tests:</b>	<b>Date:</b>	<b>Date:</b>	<b>Date:</b>	<b>Date:</b>
Height				
Weight				
BMI				
Blood Pressure	/	/	/	/
Foot exam	R                      L	R                      L	R                      L	R                      L
<input type="checkbox"/> Referral    Date: _____	<input type="checkbox"/> NL <input type="checkbox"/> NL	<input type="checkbox"/> NL <input type="checkbox"/> NL	<input type="checkbox"/> NL <input type="checkbox"/> NL	<input type="checkbox"/> NL <input type="checkbox"/> NL
Specialist: _____	<input type="checkbox"/> + S/Sx <input type="checkbox"/> + S/Sx	<input type="checkbox"/> + S/Sx <input type="checkbox"/> + S/Sx	<input type="checkbox"/> + S/Sx <input type="checkbox"/> + S/Sx	<input type="checkbox"/> + S/Sx <input type="checkbox"/> + S/Sx
Retinal eye exam (annually)	<input type="checkbox"/> No retinopathy <input type="checkbox"/> + Retinopathy <input type="checkbox"/> Follow up needed			<b>Notes:</b>
Date of exam: _____				
Eye Doctor: _____				
<b>Labs:</b>				
HgbA1c (goal < 7.0) <i>at least q 6 months if controlled</i> <i>at least q 3 months if uncontrolled</i>	Collection date:	Collection date:	Collection date:	Collection date:
	Result:	Result:	Result:	Result:
Nephropathy screening <i>at least annually</i> <b>-OR-</b> <input type="checkbox"/> Evidence of nephropathy Dx: _____	Urine test for albumin or protein		ACE / ARB therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Collection date: _____		If "yes"	
	Type of test: _____		Rx name: _____	
	Result: _____		Date Rx last renewed: _____	
Lipid profile <i>at least annually</i> Collection date: _____ (Results to the right)	Total cholesterol: LDL: HDL: Triglycerides:			<b>Notes:</b>
<b>Foundations of Care</b>				
<b>Self-management education</b>	<b>Date:</b>	<b>Date:</b>	<b>Date:</b>	<b>Date:</b>
	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given
<b>Nutrition counseling</b>	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given
<b>Physical activity counseling</b>	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given	<input type="checkbox"/> Discussed <input type="checkbox"/> Referral given
<b>Smoking</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Quitline info given	<input type="checkbox"/> Quitline info given	<input type="checkbox"/> Quitline info given	<input type="checkbox"/> Quitline info given
<b>Psychosocial Screening</b>	<input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other _____ <input type="checkbox"/> Result _____	<input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other _____ <input type="checkbox"/> Result _____	<input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other _____ <input type="checkbox"/> Result _____	<input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other _____ <input type="checkbox"/> Result _____
<b>Immunizations</b> <i>See ACIP recommendations on pneumococcal vaccine</i>	Influenza (annually) Date administered: _____		Pneumococcal vaccine: <input type="checkbox"/> PCV13 <input type="checkbox"/> PPSV23 Date(s) administered: _____	
<b>Diabetes Education Classes Attended:</b>		<b>Specialists:</b>		