Diabetes Care Flow Sheet

Name:	**PMP:**
DOB:	**MR #:**
Type of Diabetes: □ **Type I** □ **Type II** □ **Other**	**Date of diagnosis:**
Co-morbidities	**Medication**
□ Hypertension □ Dyslipidemia □ PAD □ CAD □ Mental health dx □ CKD □ Foot disease □ PCOS □ Other: _____	Oral medication: □ Yes □ No _____ Insulin: □ Yes □ No _____ Home monitoring: □ Yes □ No _____

Tests:	**Date:**	**Date:**	**Date:**	**Date:**
Height				
Weight				
BMI				
Blood Pressure	/	/	/	/
Foot exam □ Referral Date: _____ Specialist: _____	R L □ NL □ NL □ + S/Sx □ + S/Sx	R L □ NL □ NL □ + S/Sx □ + S/Sx	R L □ NL □ NL □ + S/Sx □ + S/Sx	R L □ NL □ NL □ + S/Sx □ + S/Sx
Retinal eye exam (annually) Date of exam: _____ Eye Doctor: _____	□ No retinopathy □ + Retinopathy □ Follow up needed	Notes:		
Labs:				
HgbA1c (goal < 7.0) *at least q 6 months if controlled* *at least q 3 months if uncontrolled*	Collection date: Result:	Collection date: Result:	Collection date: Result:	Collection date: Result:
Nephropathy screening *at least annually* ***-OR-*** □ Evidence of nephropathy Dx: _____	Urine test for albumin or protein Collection date: _____ Type of test: _____ Result: _____		ACE / ARB therapy: □ Yes □ No *If "yes"* Rx name: _____ Date Rx last renewed: _____	
Lipid profile *at least annually* Collection date: _____ (Results to the right)	Total cholesterol: LDL: HDL: Triglycerides:		Notes:	

Foundations of Care	**Date:**	**Date:**	**Date:**	**Date:**
Self-management education	□ Discussed □ Referral given	□ Discussed □ Referral given	□ Discussed □ Referral given	□ Discussed □ Referral given
Nutrition counseling	□ Discussed □ Referral given	□ Discussed □ Referral given	□ Discussed □ Referral given	□ Discussed □ Referral given
Physical activity counseling	□ Discussed □ Referral given	□ Discussed □ Referral given	□ Discussed □ Referral given	□ Discussed □ Referral given
Smoking □ Yes □ No	□ Quitline info given	□ Quitline info given	□ Quitline info given	□ Quitline info given
Psychosocial Screening	□ PHQ-9 □ Other _____ □ Result _____	□ PHQ-9 □ Other _____ □ Result _____	□ PHQ-9 □ Other _____ □ Result _____	□ PHQ-9 □ Other _____ □ Result _____
Immunizations *See ACIP recommendations on pneumococcal vaccine*	Influenza (annually) Date administered: _____		Pneumococcal vaccine: □ PCV13 □ PPSV23 Date(s) administered: _____	

Diabetes Education Classes Attended:	**Specialists:**

American Diabetes Association. Foundations of care and comprehensive medical evaluation. Sec. 3. In Standards of Medical Care in Diabetes-2016. Diabetes Care 2016; 39 (Suppl.1):S23-S35