# Diabetes Care Flow Sheet

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

| Tests: | Date: | Date: | Date: | Date: |
|---|---|---|---|---|
| Height | | | | |
| Weight | | | | |
| BMI | | | | |
| Blood Pressure | / | / | / | / |
| Foot exam<br>□ Referral Date: ________<br>Specialist: ____________ | R L<br>□ NL □ NL<br>□ + S/Sx □ + S/Sx | R L<br>□ NL □ NL<br>□ + S/Sx □ + S/Sx | R L<br>□ NL □ NL<br>□ + S/Sx □ + S/Sx | R L<br>□ NL □ NL<br>□ + S/Sx □ + S/Sx |
| Retinal eye exam (annually)<br>Date of exam: ____________<br>Eye Doctor: ____________ | □ No retinopathy<br>□ + Retinopathy<br>□ Follow up needed | | Notes: | |

| Labs: | | | | |
|---|---|---|---|---|
| HgbA1c (goal < 7.0)<br>*at least q 6 months if controlled*<br>*at least q 3 months if uncontrolled* | Collection date:<br><br>Result: | Collection date:<br><br>Result: | Collection date:<br><br>Result: | Collection date:<br><br>Result: |
| Nephropathy screening<br>*at least annually*<br>***-OR-***<br>□ Evidence of nephropathy<br>Dx: ____________ | Urine test for albumin or protein<br>Collection date: ____________<br>Type of test: ____________<br>Result: ____________ | | ACE / ARB therapy: □ Yes □ No<br>*If "yes"*<br>Rx name: ____________<br>Date Rx last renewed: ____________ | |
| Lipid profile<br>*at least annually*<br>Collection date: ____________<br>(Results to the right) | Total cholesterol:<br>LDL:<br>HDL:<br>Triglycerides: | | Notes: | |

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

| Diabetes Education Classes Attended: | Specialists: |
|---|---|
| | |

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*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*