

Patient: \_\_\_\_\_

Office visit date: \_\_\_\_\_

# DIABETES VISIT WORKSHEET

Provider this visit: \_\_\_\_\_  
PCP/Medical Home: \_\_\_\_\_

Birth date: \_\_\_\_\_  
Gender:     M     F     U

<b>Diabetes</b>	Diabetes: <input type="radio"/> Type 1 <input type="radio"/> Type 2	<b>Comorbidities</b>	<input type="checkbox"/> CAD	<input type="checkbox"/> Hypertension
	Year of first diagnosis: _____		<input type="checkbox"/> PVD	<input type="checkbox"/> Renal Failure/Proteinuria
			<input type="checkbox"/> Foot Ulceration/Amputation	<input type="checkbox"/> Retinal disease
			<input type="checkbox"/> TIA/Stroke/CVD	<input type="checkbox"/> Depression
			<input type="checkbox"/> Peripheral neuropathy	<input type="checkbox"/> None

<b>Patient Goals</b>	Blood pressure:	<b>Functional goal:</b> e.g., "Walk to grocery store"
	Weight:	
	HbA1c:	
		<b>Home blood glucose monitoring?:</b> e.g., Only able to test twice a week due to cost of strips

<b>Blood Pressure</b>	<b>Recommended blood pressure target &lt; 130/80.</b>
	Blood pressure: _____      Weight: _____      Height: _____

<b>Glucose</b>	<b>Recommended HbA1c target &lt; 7.0.</b>
	RECENT VALUES    Date: _____    Result : _____    Lab: _____

<b>Cholesterol</b>	<b>Recommended LDL target &lt; 100 and triglycerides target &lt; 150. If diabetes and cardiovascular disease LDL &lt; 70.</b>
	RECENT VALUES Date: _____    TC: _____    LDL: _____    TG: _____    HDL: _____    Lab: _____

<b>Microalbuminuria</b>	<b>Recommend microalbuminuria test at least once annually.</b>
	RECENT TEST    Date: _____    Result : _____    Lab: _____

<b>Aspirin</b>	<b>Recommend taking at least 81 mg a day unless contraindicated.</b>
	Is patient using Aspirin? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Contraindicated

<b>ACE/ARB</b>	<b>Consider Ace Inhibitor if hypertension or proteinuria is present.</b>
	Is patient using ACE inhibitor? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Contraindicated

<b>Beta Blockers</b>	<p><b>i</b> If history of myocardial infarction, beta blocker is recommended unless contraindicated.</p>
	<p>Is patient using beta blocker?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> Contraindicated</p>

<b>Depression</b>	<p><b>i</b> Recommend asking patient two screening questions.</p>
	<p>1) During the past month have you often been bothered by feeling down, depressed or hopeless?    <input type="radio"/> Yes    <input type="radio"/> No</p>
	<p>2) During the past month have you often little interest or pleasure in doing things?    <input type="radio"/> Yes    <input type="radio"/> No</p>
	<p><b>INTERVENTION</b></p> <p><input type="checkbox"/> Ongoing counseling                      <input type="checkbox"/> On anti-depressant meds</p> <p><input type="checkbox"/> Referred counseling                      <input type="checkbox"/> Prescribed anti-depressant meds</p>

<b>Retinal</b>	<p><b>i</b> Recommended annually for Type 2 diabetes and after 5 years for Type 1 diabetes.</p>
	<p><input type="checkbox"/> Referred for retinal exam this visit? _____  <small>Provider's name</small></p>

<b>Oral</b>	<p><b>i</b> Dental exams are recommended at least twice yearly. Hygiene visit two to four time a year.</p>
	<p>Does patient have regular source of dental care?    <input type="radio"/> No    <input type="radio"/> Yes    Dentist: _____</p>
	<p><input type="checkbox"/> Grade 1: No visible disease</p>
	<p><input type="checkbox"/> Grade 2: Red or Swollen gums</p> <p><input type="checkbox"/> Grade 3: Severe dental disease. Mouth pain. <b>🚨 Recommend patient seek immediate dental care.</b></p>

<b>Foot</b>	<p>Feet examined this visit?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> Not applicable</p>
	<p><input type="checkbox"/> Referred for podiatrist new problem? _____  <small>Provider's name</small></p>

<b>Smoking</b>	<p>Does patient smoke?    <input type="radio"/> No    <input type="radio"/> Yes    <input type="checkbox"/> Counseled this visit</p>
	<p> </p>

<b>Education</b>	<p>Diabetes education referral this visit?    <input type="radio"/> Yes    <input type="radio"/> Patient refused</p>
	<p><b>SEND REFERRAL</b></p>
	<p><input type="checkbox"/> Diabetes Health Center    <input type="checkbox"/> Dominican Lifestyle Center    <input type="checkbox"/> SCMF Health Education</p>

<b>Immunization</b>	<p><b>FLU SHOT:</b>    <input type="checkbox"/> Given today _____ mm/dd/yyyy    <input type="checkbox"/> Given elsewhere _____ mm/dd/yyyy</p>
	<p><b>PNEUMOCOCCAL SHOT:</b> <input type="checkbox"/> Given today _____ mm/dd/yyyy    <input type="checkbox"/> Given elsewhere _____ mm/dd/yyyy</p>

<b>Notes</b>	<p><b>OPTIONAL CLINICIAN'S NOTE:</b></p>
	<p> </p>