

Patient:

# DIABETES VISIT WORKSHEET

Office visit date:

Provider this visit: \_\_\_\_\_

PCP/Medical Home: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

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	
<b>Patient Goals</b>	Blood pressure:	<b>Functional goal:</b>	<input type="checkbox"/> Foot Ulceration/Amputation		<input type="checkbox"/> Retinal disease
	Weight:		<input type="checkbox"/> TIA/Stroke/CVD	<input type="checkbox"/> Depression	
	HbA1c:		<input type="checkbox"/> Peripheral neuropathy	<input type="checkbox"/> None	
		e.g., "Walk to grocery store"			
		<b>Home blood glucose monitoring?:</b>			
		e.g., Only able to test twice a week due to cost of strips			

**Blood Pressure**

**Recommended blood pressure target < 130/80.**

Blood pressure: \_\_\_\_\_ / \_\_\_\_\_ Weight: \_\_\_\_\_

PAST READINGS	Date	BP	Weight	BMI	Height:

**HbA1c**

**Recommended HbA1c target < 7.0.**

Date	Result	Lab

MORE RECENT VALUE? \_\_\_\_\_

**Cholesterol**

**Recommended LDL target < 100 and triglycerides target < 150. If diabetes and cardiovascular disease LDL < 70.**

Date	TC	LDL	TG	HDL	Lab

MORE RECENT VALUES? \_\_\_\_\_

<b>Microalbuminuria</b>	<b>ⓘ Recommend microalbuminuria test at least once annually.</b>		
	LAST TEST	Results: _____	Lab: _____
	MORE RECENT TEST? _____		

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

<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

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

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

<b>Retinal</b>	<b>ⓘ Recommended annually for Type 2 diabetes and after 5 years for Type 1 diabetes.</b>		
	<input type="checkbox"/> Referred for retinal exam this visit?	_____	
		Provider's name	
	LAST EXAM RECORDED	Date: _____	Provider: _____
MORE RECENT EXAM? _____			

**Oral**

**ⓘ Dental exams are recommended at least twice yearly. Hygiene visit two to four time a year.**

Does patient have regular source of dental care?  Yes  No **Dentist:**

Grade 1: No visible disease

Grade 2: Red or Swollen gums

Grade 3: Severe dental disease. Mouth pain. **⚠ Recommend patient seek immediate dental care.**

**Foot**

Feet examined this visit?  Yes  No  Not applicable

Referred to podiatrist for new problem: \_\_\_\_\_  
Doctor's or Nurse name

**PREVIOUS EXAM**    **Date:** \_\_\_\_\_    **Doctor:** \_\_\_\_\_

**Smoking**

Does patient smoke?  Yes  No  Counseled this visit

**Education**

Diabetes education referral this visit?  Yes  No  Patient refused

<p><b>SEND REFERRAL</b></p> <p><input type="checkbox"/> Diabetes Health Center</p> <p><input type="checkbox"/> Dominican Lifestyle Center</p> <p><input type="checkbox"/> SCMF Health Education</p>	<p><b>LAST DIABETES EDUCATION VISIT</b></p> <p><b>Date:</b> _____    <b>Provider:</b> _____</p>
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**Immunization**

**LAST FLU SHOT:**    **Date:** \_\_\_\_\_     Given today     Given elsewhere \_\_\_\_\_  
mm/dd/yyyy

**LAST PNEUMOCOCCAL SHOT:**    **Date:** \_\_\_\_\_     Given today     Given elsewhere \_\_\_\_\_  
mm/dd/yyyy

**Pharmacy Data**

Drug Name/Dose	Drug Class	Prescription Will Last	First Filled Date	Usage %	Prescribing Provider

**Physician Notes**

**OPTIONAL CLINICIAN'S NOTE:**