

DIABETES FLOW SHEET (designed to cover 4 visits/year-add additional sheets as needed)

Patient Name _____ DOB ___/___/___ Male___ Female___

Height ___ft ___in Date of Diagnosis ___/___/___ Type 1___ 2___

HTN Yes___ No___ On ACEI/ARB Yes___ No**___ CKD Stage 1__2__3__4__5__

Vaccines: Pneumonia ___/___/___ Td ___/___/___ PPD ___/___/___ Positive? Yes___ No___

**** Document reason in record (contraindications, etc) Note any patient refusals to any measure(s)**

	Date/Result			
Each Visit	Weight			
	Glucose			
	Blood Pressure Goal <130/80 mmHg			
3-4 Mos	HbA1c Goal < 7.0			
Yearly	Microalbumin			
	Serum Creatinine/(eGFR)			
	Nephrology Consult (at Stage 3+)			
	Fasting lipids			
	Influenza Vaccine			
	Dilated Eye Exam			
	Foot Exam (visual, sensory, monofilament, pulses,)			
	Dental Exam			
Prevention/Education	Diabetes Educator Referral			
	Diet Instruction			
	Exercise Instruction			
	Smoking cessation			
	Depression screening			
	Mammogram screening			
	Colorectal cancer screening			

