

Diabetes Mellitus Flow Sheet*

Developed by the **New York Diabetes Coalition****
in collaboration with the New York State Dept. of Health, Diabetes Prevention & Control Program. Based on the American Diabetes Association Clinical Practice Recommendations. Visit www.diabetes.org for full recommendations.



Name: _____

ID/SSN/MRN: _____

DOB: _____

Height: _____ Date Recorded: _____ Sex: M F Other Care Clinicians: _____

Record date of visit at top of column and results of any ordered test in the appropriate box below. Check the box when item complete (✓), or mark with "D" if patient declined.

EXAMINATION/TEST	Date	/	/	/	/	/	/
Complete History and Physical Exam (including risk factors, exercise, and diet history) Initial visit and annual at discretion of clinician		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Goal: <130/80	Every visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight/BMI Goal: BMI ≥18.5 < 25	Every visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive Foot Exam Sensory, visual and vascular inspection, without shoes and socks	Every visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Eye Exam Type 1: Annual, beginning 5 years from onset Type 2: At diagnosis, then annually		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Evaluate teeth and gums, refer to dentist	Every 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A1C Goal: <7.0%	Every 3-6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting Lipid Profile Goal: LDL <100 mg/dl; Triglycerides <150 mg/dl HDL >50 mg/dl for women; >40 mg/dl for men Pts with overt CVD, lower LDL to goal of <70 mg/dl	Annual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Microalbumin/Creatinine Ratio Perform test on spot urine ≥30ug alb/mg creatinine is abnormal	Annual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serum Creatinine to estimate Glomerular Filtration Rate (See NYDC Guidelines)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu Vaccine	Annual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumovax	Per NYDC Guidelines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Risk Behaviors	Smoking Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled
Psychosocial Adjustment Screen for depression		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Education Initial visit and at clinician's discretion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition Counseling Initial visit and at clinician's discretion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of Hyper/Hypoglycemia (review signs, symptoms and treatment)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List Current Medications (including aspirin, over-the-counter, and complementary and alternative medicine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments (e.g. assessment of complications, adherence to plan, follow up, referrals, etc.)							
Signature/Initials							

*American Diabetes Association, Standards of Medical Care for Patients with Diabetes Mellitus, Diabetes Care Vol. 31, Supplement 1, Clinical Practice Recommendations, January, 2008

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