



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.

Name: _____

ID/MRN: _____

DOB: _____

Height: _____ Date Recorded: _____ Sex: M F

Other Care Clinicians: _____

Record visit date at top of column, record test results and/or service date(s) in spaces below.

Check (✓) when item complete; mark with "C" if item is contraindicated; "D" if patient declined; "R" if referred.

Highlighted items are required for one or more nationally endorsed diabetes management clinical performance measures.

| EXAMINATION/TEST | FREQUENCY | VISIT DATE / / | VISIT DATE / / | VISIT DATE / / | VISIT DATE / / |
|--|--|--|--|--|--|
| Complete History and Physical Exam (including risk factors, exercise, and diet history) | Initial visit and annually at discretion of clinician | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Pressure Goal: <130/80 | Every visit | <input type="checkbox"/> BP: ____ / ____ | <input type="checkbox"/> BP: ____ / ____ | <input type="checkbox"/> BP: ____ / ____ | <input type="checkbox"/> BP: ____ / ____ |
| Weight & BMI Goal: BMI ≥18.5 and <25 | Every visit | <input type="checkbox"/> Wgt: _____ <input type="checkbox"/> BMI: _____ | <input type="checkbox"/> Wgt: _____ <input type="checkbox"/> BMI: _____ | <input type="checkbox"/> Wgt: _____ <input type="checkbox"/> BMI: _____ | <input type="checkbox"/> Wgt: _____ <input type="checkbox"/> BMI: _____ |
| Comprehensive Foot Exam Sensory/monofilament and Pulses | Annually | <input type="checkbox"/> Sensory/monofilmt <input type="checkbox"/> Pulses | <input type="checkbox"/> Sensory/monofilmt <input type="checkbox"/> Pulses | <input type="checkbox"/> Sensory/monofilmt <input type="checkbox"/> Pulses | <input type="checkbox"/> Sensory/monofilmt <input type="checkbox"/> Pulses |
| Visual Inspection of Feet | Every visit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dilated Retinal Exam | Annually* | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental | Every 6 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A1C General Goal: <7.0* | Two to four times yearly* | <input type="checkbox"/> A1C: _____ | <input type="checkbox"/> A1C: _____ | <input type="checkbox"/> A1C: _____ | <input type="checkbox"/> A1C: _____ |
| Fasting Lipid Profile LDL-C <100mg/dl* | Annually* | <input type="checkbox"/> LDL-C: _____ | <input type="checkbox"/> LDL-C: _____ | <input type="checkbox"/> LDL-C: _____ | <input type="checkbox"/> LDL-C: _____ |
| Urine Microalbumin/Creatinine Ratio* ≥30 µg alb/mg creatinine is abnormal | At diagnosis and annually | <input type="checkbox"/> Ratio: _____ | <input type="checkbox"/> Ratio: _____ | <input type="checkbox"/> Ratio: _____ | <input type="checkbox"/> Ratio: _____ |
| eGFR (Calculated from Serum Creatinine)* | Annually | <input type="checkbox"/> eGFR: _____ | <input type="checkbox"/> eGFR: _____ | <input type="checkbox"/> eGFR: _____ | <input type="checkbox"/> eGFR: _____ |
| Flu Vaccine October 1–March 31 | Annually | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumovax | Once or twice* | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discuss High Risk Behaviors Counsel on smoking cessation and alcohol use | Every visit 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 | <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 or other mood disorder | Annual/Ongoing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discuss Sexual Functioning* | Annual/Ongoing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discuss Preconception/Pregnancy Many Medications contraindicated* | Initial/Ongoing* | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes Self-Management Education (DSME) | Initial visit and at clinician's discretion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-Management Goal Assessment Review patient's goals for self-management* including dietary needs, physical activity | Initial/Ongoing | <input type="checkbox"/> Self-Mgmt. goal: | <input type="checkbox"/> Self-Mgmt. goal: | <input type="checkbox"/> Self-Mgmt. goal: | <input type="checkbox"/> Self-Mgmt. goal: |
| Medical Nutrition Therapy (MNT) Assess and refer as needed | Initial/Ongoing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Assessment of Hyper/Hypoglycemia Review signs, symptoms and treatment Review self-monitoring blood glucose record | Initial/Ongoing | <input type="checkbox"/> <input type="checkbox"/> SMBG | <input type="checkbox"/> <input type="checkbox"/> SMBG | <input type="checkbox"/> <input type="checkbox"/> SMBG | <input type="checkbox"/> <input type="checkbox"/> SMBG |
| Review Current Medications and Medication Adherence* Include all medications to control glucose, blood pressure and lipids, aspirin/anti-platelet agents; ACEIs/ARBs; insulin/oral hypoglycemic agents; statins/lipid control agents; over-the-counter, complementary and alternative medicine. Review/adjust medications as indicated to achieve target goals for glucose, blood pressure and lipids. | Initial/Ongoing Check (✓) box if currently prescribed Mark "C" if item is contraindicated Mark "D" if patient declined Mark "A" if medication adjusted Mark "X" if medication stopped | <input type="checkbox"/> Insulin <input type="checkbox"/> Oral hypoglycemic <input type="checkbox"/> ACEI/ARB <input type="checkbox"/> Statin/lipid control <input type="checkbox"/> ASA/anti-platelet | <input type="checkbox"/> Insulin <input type="checkbox"/> Oral hypoglycemic <input type="checkbox"/> ACEI/ARB <input type="checkbox"/> Statin/lipid control <input type="checkbox"/> ASA/anti-platelet | <input type="checkbox"/> Insulin <input type="checkbox"/> Oral hypoglycemic <input type="checkbox"/> ACEI/ARB <input type="checkbox"/> Statin/lipid control <input type="checkbox"/> ASA/anti-platelet | <input type="checkbox"/> Insulin <input type="checkbox"/> Oral hypoglycemic <input type="checkbox"/> ACEI/ARB <input type="checkbox"/> Statin/lipid control <input type="checkbox"/> ASA/anti-platelet |
| Comments (e.g. assessment of complications, adherence to plan, follow up, referrals, etc.) | | | | | |
| Signature/Initials | | | | | |

* See Guidelines on reverse for details and exceptions.

**American Diabetes Association, Standards of Medical Care for Patients with Diabetes Mellitus, Diabetes Care Vol. 34, Supplement 1, Clinical Practice Recommendations, January, 2011.

To access the current American Diabetes Association Clinical Practice Recommendations, go to http://professional.diabetes.org/CPR_search.aspx

The ADA Clinical Practice Guidelines are reviewed yearly.