



TELEPHONIC MONITORING FOR DIABETIC PATIENTS

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_
PATIENT ID #: \_\_\_\_\_ CALL START TIME: \_\_\_\_\_
INTERVIEWER: \_\_\_\_\_ CALL END TIME: \_\_\_\_\_

I. Have you been hospitalized or have you required emergency care since your nurse last visited? [ ] No [ ] Yes

II. HYPERGLYCEMIA

Since the nurse last visited, have you had:

- 1. Increased thirst? [ ] No [ ] Yes
2. Dry mouth? [ ] No [ ] Yes
3. Decreased appetite? [ ] No [ ] Yes
4. Nausea or vomiting? [ ] No [ ] Yes
5. Abdominal pain? [ ] No [ ] Yes
6. Frequent urination? [ ] No [ ] Yes
7. Blurred vision? [ ] No [ ] Yes

If yes to any, actions taken: \_\_\_\_\_

III. HYPOGLYCEMIA

Since the nurse last visited, have you had:

- 1. Lightheadedness? [ ] No [ ] Yes
2. Shakiness or weakness? [ ] No [ ] Yes
3. Intense hunger? [ ] No [ ] Yes
4. Times when you passed out, fainted, or lost consciousness? [ ] No [ ] Yes
5. Confusion? [ ] No [ ] Yes

If yes to any, actions taken: \_\_\_\_\_

IV. NUTRITION

Tell me what you ate yesterday: \_\_\_\_\_

If not following diet regime, educate on correct diet. Consider co-morbidities such as hypertension.

V. EXERCISE

- 1. In the past week what exercise activities have you done? \_\_\_\_\_
2. How many days did you exercise? \_\_\_\_\_
3. How many minutes each day did you exercise? \_\_\_\_\_

VI. MEDICATIONS

- 1. What medications are you taking for diabetes? \_\_\_\_\_
2. What time(s) of the day do you take your diabetes medication? \_\_\_\_\_
3. How much (dose) do you take each time? \_\_\_\_\_

Note: Verify the medication taken, dose, and time are correct. If not, inquire if the physician changed the medications. If the patient is not taking medications that were prescribed, what is the reason? (S.E., unable to afford, etc.)

VII. GLUCOSE MONITORING

- 1. Do you use anything to monitor your blood sugar? [ ] No Yes - What? \_\_\_\_\_
2. How many times a day do you test your blood sugar? \_\_\_\_\_
3. What have your blood sugars been over the last few days? \_\_\_\_\_
4. Since your nurse last visited, what was your highest blood sugar? \_\_\_\_\_
5. Since your nurse last visited, what was your lowest blood sugar? \_\_\_\_\_

\*\*\*\*\* TO BE COMPLETED BY INTERVIEWER\*\*\*

VIII. Did the patient identify other problems? [ ] No [ ] Yes - Explain: \_\_\_\_\_

IX. Recommendations for care/teaching: \_\_\_\_\_

X. Case Manager given report: \_\_\_\_\_ (Date/Time) By: \_\_\_\_\_ (Name)