

## DIABETES PATIENT FLOW SHEET/CHART AUDIT TOOL

Patient Name \_\_\_\_\_ ID \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of Diabetes: Type 1 Type 2 Gestational Other Date of Dx: \_\_\_\_/\_\_\_\_/\_\_\_\_

SBGM: Yes No Treatment (check all that apply): Insulin Oral Medication(s) Diet Physical Activity

*Instructions: Please indicate date of exam/test, "A" for abnormal or "N" for normal, as well as the actual results, when appropriate (e.g., lab value), "D" if done elsewhere, and "R" if referred. Additional explanations should be written in the patient's clinical notes.*

General Office Visits	date/results	date/results	date/results	date/results	date/results	date/results
Review management plan <i>Type 1: every 3 months Type 2: every 3-6 months</i>						
Review physical activity <i>each visit</i>						
Weight						
Height						
BMI						
<b>Self-Management Training</b>						
<i>At diagnosis, then every 6-12 months or more as needed</i>						
<b>Medical Nutrition Therapy</b>						
<i>At diagnosis, then, Type 1: age &lt; 18, every 3-6 months; age ≥ 18, every 6-12 months or more as indicated Type 2: every 6-12 months or more as indicated</i>						
<b>Glycemic Control</b>						
A1c test <i>every 3-6 months</i>						
Review A1c target goal <i>each visit</i>						
<b>Cardiovascular Care</b>						
Lipid Profile <i>Children: age &gt; 2 yrs, after dx when in glycemic control; Adults: annually</i>						
Total Cholesterol						
TG						
HDL						
Non-HDL						
LDL						
Blood pressure <i>each visit</i>						
Smoking status <i>each visit</i>						
Smoking cessation referral <i>if indicated</i>						
Aspirin therapy <i>if indicated</i>						
<b>Kidney Care</b>						
Albumin to creatinine ratio <i>Type 1: begin with puberty or after 5 yrs duration, then annually Type 2: at dx, then annually</i>						
Protein to creatinine ratio <i>annually after microalbumin &gt; 300 mg/24 hrs.</i>						
Serum creatinine <i>annually</i>						
ACE/ARB therapy						
<b>Eye Care</b>						
Dilated eye exam <i>Type 1: If age &gt; 10 years, within 3- 5 years of onset, then annually Type 2: At diagnosis, then annually</i>						
<b>Foot Care</b>						
Inspect bare feet and stress self-exam <i>each visit</i>						
Comprehensive lower extremity exam <i>annually</i>						
<b>Oral Care</b>						
Oral health screening <i>each visit</i>						
Refer to dentist <i>every 6 months</i>						
<b>Emotional/Sexual Health Care Concerns</b>						
List: _____						
List: _____						
<b>Preconception/Pregnancy</b>						
Assess contraception/discuss family planning <i>at diagnosis and each focused visit during childbearing yrs</i>						
Preconception consult <i>3-4 months prior to conception</i>						
<b>Immunizations</b>						
Influenza <i>annually</i>						
Pneumococcal <i>once; revaccination per ACIP</i>						