DIABETES CARE TOOL

KENTUCKY DIABETES NETWORK, INC.

A statewide partnership striving to improve the treatment and outcomes for Kentuckians with diabetes.

Patient Name: _____ **DOB:** _____

Type of Diabetes: 1 2 (circle one) **Year Diagnosed:** _____ **Tobacco Use: Yes No** (circle one)

Vaccine Date(s) Pneumococcal DPCV13: _____ **PPSV23:** _____ _____ **Hep B Series:** _____ _____ _____

*This tool is based on the **2020** American Diabetes Association's "Standards of Medical Care for Patients with Diabetes Mellitus" and indicates minimum services to be provided in the continuing (initial visits have additional components) care of **adults** with diabetes. It is not intended to replace or preclude clinical judgement or more intensive management where medically indicated. Use it as a reminder for exams or important tests, to simplify record keeping, and as a way to continually improve care to all patients with diabetes. Refer to the American Diabetes Association for current standards of care as they are updated as research indicates. https://care.diabetesjournals.org/content/43/Supplement_1/S1*

Enter result, checkmark, initials or date as you deem appropriate.

	DATE OF VISIT						
EVERY VISIT	**Weight** **BMI** **Height in inches** _____						
	B/P (Goal <140/90)						
	A1C Every 3–6 mo. (Goal individualized according to age and health history)						
	Foot Exam: V = Visual						
	Review and Update Self-Management Goals, Blood Glucose Log and Hypoglycemic Events						
ANNUAL	**Foot Exam:** • **Monofilament (sensation), foot structure, biomechanics, vascular, and skin integrity**						
	Assess Urine Albumin Excretion						
	Serum Creatinine/eGFR						
	Dilated Eye Exam (biannual exams may be considered where no evidence of retinopathy) **R=**Referral **D+ date=**Date Done						
	Flu Vaccine						
	Oral Exam (Visual)						
INDIVIDUALIZED	**Fasting Lipid Profile:** (at diagnosis, at initial medical evaluation, and every 5 years thereafter, or more frequently if indicated) • **Total Cholesterol** (Goal < 200)						
	• **LDL** (Goal < 100)						
	• **HDL** (Goal Men > 40, Women > 50)						
	• **Triglycerides** (Goal < 150)						
SELF-MANAGEMENT	**Self-Management Education** (at diagnosis, annual assessment as needed, new complicating factors, and transitions of care) **R**=Referral **D+ date**=Date Done **(https://prd.chfs.ky.gov/KYDiabetesResources/)**						
	MLU= Medication List Update **APAB**=Assess Patient Adherence/Barriers **PC=**Pharmacist Consult						
	Medical Nutrition Therapy **R**=Referral **D+ date**=Date Done						
	Instruct: PA=Physical Activity **T**=Tobacco Cessation **(1-800-QUIT NOW or 1-800-784-8669)**						
	Preconception Counseling (women of childbearing age)						
OTHER	**Consider:** • **Aspirin Therapy** **St**=start, **Cont**=continue, **D/C**=discontinue, **NI/MA**=not indicated/medical allergy, **Dec**=declined						
	• **Statin or Lipid Lowering Agent** **St, Cont, D/C. NI/MA, Dec**						
	• *Circle*: **ACE-I or ARB** **St, Cont, D/C, NI/MA, Dec**						
	Assess Mental/Behavioral Health						

06/2020