Diabetes Follow-Up Sheet

Name:_____ **Date Diagnosed**:_____ **Type DM**:_____

Comorbidities: Hypertension____ Dyslipidemia____ Nephropathy__

Neuropathy____ Retinopathy____ CVD__

Other_____

Risk Factors: Sedentary____ Smoker____ IGT/IFG___ Ethnicity____

Overweight___ CVD____ Medications___ Family History____

Medications

Date	Oral Hypoglycemics	Insulin	Lipid-Lowering	Anti-Hypertensives	ASA	Other

Quarterly Review

Yearly Review (or as clinically needed)

Test/Target	Date	Date	Date	Date	Date	Date	Date	Date	Date	
Weight (BMI)										
BP (130/80)										
A1c (<7%)										
Pre-Prandial (4-7)										
Post-Prandial (5-10)										
LDL (<2.5)										
TC:HDL (<4.0)										
Scr										
Clcr										
Retinopathy Screening										
Neuropathy Testing										
Erectile Dysfunction										
Immunization Pneumonia (lifetime) Influenza (yearly)										

Patient Follow-Up (√ when completed)

Education:	Disease Process	_____
	Understanding of comorbidities	_____
	Medication(s)	_____
	Hypoglycemia awareness/treatment	_____
	Complication prevention	_____
	Sick day planning	_____
Self-Monitoring:	Monitoring methods and techniques	_____
	Accurate recording of levels	_____
	Understanding of levels and targets	_____
	Ability to respond to levels	_____
Lifestyle:	Smoking cessation counseling	_____
	Physical activity counseling	_____
	Weight control counseling	_____
	Nutrition counseling	_____

Referrals (Date): Patient Consent Received/ Y / N

-Dietitian _____ -Podiatry _____ -Optometry _____

-Pharmacy _____ -Home care _____ -Family Physician___

-Nurse Practioner _____ -Psychiatry/Social Work ____-Therapies _____

Progress Notes (Sign & Date):

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Progress Notes (Sign & Date)