

Diabetes Visit Assessment Tool*

| | |
|---------------|----------------|
| Patient name: | Date of birth: |
| Phone number: | Gender: |

| Care | Frequency | Visit date | Visit date | Visit date | Visit date |
|---|---|--|--|--|--|
| | | / / | / / | / / | / / |
| Complete history & physical exam | Initial visit and annually | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure Goal: <140/90 | Every visit | BP: / | BP: / | BP: / | BP: / |
| Weight & BMI BMI goal: 18.5 -24.9 | Every visit Height: _____ | Weight: _____ BMI: _____ | Weight: _____ BMI: _____ | Weight: _____ BMI: _____ | Weight: _____ BMI: _____ |
| A1c Goal: <7 | 2-4 times a year | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fasting lipid panel LDL: <100 HDL: >40 M; >50 F Triglycerides: <150 | Periodically | <input type="checkbox"/> LDL <input type="checkbox"/> HDL <input type="checkbox"/> Triglycerides | <input type="checkbox"/> LDL <input type="checkbox"/> HDL <input type="checkbox"/> Triglycerides | <input type="checkbox"/> LDL <input type="checkbox"/> HDL <input type="checkbox"/> Triglycerides | <input type="checkbox"/> LDL <input type="checkbox"/> HDL <input type="checkbox"/> Triglycerides |
| Urine protein test | Annually | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Serum creatinine | Annually | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flu vaccine | Every flu season | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumonia vaccine | 1-2 doses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis B vaccine | 3 doses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Comprehensive foot exam | Annually Visual inspection every visit | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| Depression/mood disorder screening | Annually/ongoing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diet & physical activity counseling | Ongoing/refer as needed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes education (DSME) | Ongoing/refer as needed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self blood glucose monitoring record assessment | Ongoing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication review Insulin Orals ACE/ARB Statins ASA Other | Review every visit | <input type="checkbox"/> Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____ | <input type="checkbox"/> Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____ | <input type="checkbox"/> Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____ | <input type="checkbox"/> Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____ |
| Comments (Plan adherence, follow-up, referrals etc.) | Ongoing | | | | |
| Signature | | | | | |

*Recommendations based on the American Diabetes Association Standards of Medical Care - 2018