Diabetes Checklist

Name_____

DOB_____/_____/_____

Flowsheet Start Date_____/_____/_____

***Not Provided Reason**:

1. Not indicated
2. Forgot
3. No time
4. Patient
5. Patient Ill
6. Other

Treatment	Date/Result	Date/Result	Date/Result	Date/Result
BP Every visit	/ /	/ /	/ /	/ /
Weight Every visit	/ /	/ /	/ /	/ /
Foot exam Every visit	/ /	/ /	/ /	/ /
Diet Assess./Instruct, Every visit	/ /	/ /	/ /	/ /
Hgb A1c Quarterly if poor control; 2x/yr if stable	/ /	/ /	/ /	/ /
Patient Education Once or more/yr	/ /	/ /	/ /	/ /
Dilated Retinal Exam Annually	/ /	/ /	/ /	/ /
Cholesterol Annually	/ /	/ /	/ /	/ /
Triglycerides Annually	/ /	/ /	/ /	/ /
HDL Annually	/ /	/ /	/ /	/ /
LDL Annually	/ /	/ /	/ /	/ /
Urinalysis Annually	/ /	/ /	/ /	/ /
Microalbumin Annually	/ /	/ /	/ /	/ /
Baseline EKG Annually	/ /	/ /	/ /	/ /
PSA Annually	/ /	/ /	/ /	/ /
Flu Shot Annually	/ /	/ /	/ /	/ /
Pneumovax Every 5 years	/ /	/ /	/ /	/ /
DT Every 10 years	/ /	/ /	/ /	/ /
Mammogram Annually	/ /	/ /	/ /	/ /
Pap Smear Every 2 years	/ /	/ /	/ /	/ /
Colon Cancer Screen Age 50≥	/ /	/ /	/ /	/ /
FSBS PRN	/ /	/ /	/ /	/ /
Other	/ /	/ /	/ /	/ /