DIABETES AND GENERAL PREVENTION FLOW SHEET

PATIENT: _____ **D.O.B.:** _____ **MR#:** _____

PROVIDER: _____ **HEIGHT:** _____

	EXAM/TEST	***Date:***									
EVERY VISIT	**Weight/BMI**[1] Goal BMI<25	Value									
	Blood pressure Systolic<130; Diastolic<80	Value									
	Review blood glucose record[2]	✓ when done									
	Review elements of management plan[3]	✓ when done									
	Foot exam[4] (Visual)	✓ when done									
	Hemoglobin A1c[5] < 7%	Value									
	Aspirin (age > 40) (75-162 mg/d if no contraindications)	✓ if taking									

	EXAM/TEST	***Year performed:***	***20___***	***20___***	***20___***	***20___***	***20___***
YEARLY	**Dilated eye exam**[6]	Date					
	Oral/dental exam	Date					
	Foot exam[7] (Neurovascular)	Date					
	Albumin:creatinine ratio[8]	Date/value					
	Glomerular filtration rate[9]	Date/value					
	Hemoglobin[10]	Date/value					
	Lipid profile[11]	Date/values					
	Diabetes education/ nutrition referral[12]	Date					
	Flu vaccine	Date					
	Microalbuminuria	Date					
	Clinical breast exam/ Prostate exam[13]	Date (circle exam)					
	PAP/PSA[13] (circle exam)	Date/result					
	Mammogram	Date/result					
	Fecal occult blood test	Date/result					

LESS OFTEN	**Pneumococcal vaccine**[14]	Date			**Td** Date			**EKG**[15] Date			
	Bone densitometry	Date					**Sigmoidoscopy/ colonoscopy** Date				

See page 2 for additional information on the numbered items.

AMERICAN DIABETES ASSOCIATION CLINICAL PRACTICE GUIDELINES
More information is available online at www.diabetes.org

1. **Weight/BMI**
   BMI 25-29.9 = overweight
   BMI ≥ 30 = obese

2. **Review blood glucose record**
   Preprandial glucose: 90-130 mg/dl
   Postprandial glucose: <180 mg/dl (postprandial glucose measurements should be made one to two hours after the beginning of a meal)

3. **Review elements of management plan**
   Elements of management plan (not included elsewhere on the flow sheet) include:
   - General knowledge of diabetes
   - Medication review
   - Review of exercise regimen
   - Assessment of frequency of hypoglycemic episodes
   - Smoking cessation counseling
   - Follow-up of referrals
   - Self management skills, such as sick day management
   - Psychological/psychosocial adjustment

4. **Foot exam**
   Visual foot inspection every visit if neuropathy present.

5. **Hemoglobin A1c**
   Check every three to six months.

6. **Dilated eye exam**
   Type 1 diabetes: annually beginning three to five years from diagnosis
   Type 2 diabetes: annually beginning at the time of diagnosis

7. **Foot exam**
   Annual comprehensive exam to assess protective sensation (using a Semmes-Weinstein 5.07 [10-g] monofilament), foot structure, biomechanics, vascular status and skin integrity.

8. **Albumin:creatinine ratio**
   Annual screening of patients with Type 2 diabetes for microalbuminuria is recommended beginning at the time of diagnosis. Random urine collection for spot albumin:creatinine ratio is the preferred screening method. In areas where albumin:creatinine ratio is not available, 24 hour urine for protein (albumin) may be used.

   Albumin:creatinine ratio <30 or urinary albumin <30 mg/24 hr is considered negative. Microalbuminuria is defined as an albumin:creatinine ratio of 30-299 or urinary albumin of 30-299 mg/24 hr.

   When proteinuria is present (as indicated by an albumin:creatinine ratio >300 or urinary albumin >300 mg/24 hr), begin monitoring renal function as described in #9 and **consider a nephrology consult**.

9. **Glomerular filtration rate**
   The clinical practice guidelines (www.kdoqi.org) for chronic kidney disease (CKD) recommend the following:

   - Monitor renal function in patients with advanced diabetic nephropathy using the calculated glomerular filtration rate (GFR). A formula for calculating the GFR using serum creatinine (SCr): GFR = 186 x $(SCr)^{-1.154}$ x $(age)^{-0.203}$ x (0.72 if female) x (1.210 if African-American)

   - GFR >60 ml/min/1.73m2 – repeat annually

   - GFR ≤60 ml/min/1.73m2 – obtain CBC. **Consult with nephrologist to develop CKD management plan.**

   - GFR <30 ml/min/1.73m2 – **refer to nephrologist** for preparation for renal replacement therapy including vascular access placement.

     For alternate GFR calculation programs available online refer to www.nephron.com or www.nephron.com/cgi-bin/mdrd.cgi.

10. **Hemoglobin**
    Hgb ≥12.5 g/dl (postmenopausal women, men);
    ≥11 g/dl (women) – repeat annually

    If GFR <60 mL/min/1.73m2 and
    Hgb < 12.5 g/dl (postmenopausal women, men);
    <11 g/dl (women) – perform anemia work-up (CBC, indices, retics; iron: TIBC, Fe, TSAT, ferritin; stool guaiac) (see KDOQI guideline #8)

11. **Lipid profile goals**
    LDL <100 mg/dl
    HDL >40 mg/dl (men) or >50mg/dl (women)
    Triglycerides <150 mg/dl

12. **Diabetes education and nutrition referral**
    Referral for diabetes education and nutrition therapy initially and as needed thereafter.

13. **PAP/PSA**
    Two resources for current recommendations regarding routine screening for prostate cancer are the American Cancer Society (www.cancer.org) and the U.S. Preventive Services Task Force (www.ahrq.gov/clinic/cps3dix.htm).

14. **Pneumococcal vaccine**
    At least once in a lifetime. Persons immunized prior to age 65 should get the vaccine again if more than five years have passed since the first dose.

15. **EKG**
    EKG if patient is age >40 years and/or diabetes ≥10 years.

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