

# Diabetes Mellitus Flow Sheet\*

Developed by the **New York Diabetes Coalition\*\***  
in collaboration with the New York State Dept. of Health, Diabetes Prevention & Control Program. Based on the American Diabetes Association Clinical Practice Recommendations. Visit [www.diabetes.org](http://www.diabetes.org) for full recommendations.



Name: \_\_\_\_\_

ID/SSN/MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Date Recorded: \_\_\_\_\_ Sex:  M  F Other Care Clinicians: \_\_\_\_\_

Record date of visit at top of column and results of any ordered test in the appropriate box below. Check the box when item complete (✓), or mark with "D" if patient declined.

EXAMINATION/TEST	Date	/ /	/ /	/ /	/ /
<b>Complete History and Physical Exam</b> (including risk factors, exercise, and diet history) Initial visit and annual at discretion of clinician		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Blood Pressure</b> Every visit Goal: <130/80		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Weight/BMI</b> Every visit Goal: BMI ≥18.5 ≤25		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Comprehensive Foot Exam</b> Every visit Sensory, visual and vascular inspection, without shoes and socks		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dilated Eye Exam</b> Type 1: Annual, beginning 5 years from onset Type 2: Annual		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dental</b> Every 6 months Evaluate teeth and gums, refer to dentist		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>A1C</b> Every 3-6 months Goal: <7.0%.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Fasting Lipid Profile</b> Annual Goal: LDL <100 mg/dl; Triglycerides <150 mg/dl HDL >50 mg/dl for women; >40 mg/dl for men		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Urine Microalbumin/Creatinine Ratio</b> Perform test on spot urine      Annual ≥30ug alb/mg creatinine is abnormal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Serum Creatinine to estimate Glomerular Filtration Rate</b> (See NYDC Guidelines)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Flu Vaccine</b> Annual		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pneumovax</b> Per NYDC Guidelines		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>High Risk Behaviors</b> Smoking Alcohol		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled
<b>Psychosocial Adjustment</b> Screen for depression		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Diabetes Education</b> Initial visit and at clinician's discretion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nutrition Counseling</b> Initial visit and at clinician's discretion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Assessment of Hyper/Hypoglycemia</b> (review signs, symptoms and treatment)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>List Current Medications</b> (including aspirin, over-the-counter, and complementary and alternative medicine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Comments</b> (e.g. assessment of complications, adherence to plan, follow up, referrals, etc.)					
<b>Signature/Initials</b>					