# DIABETES FLOW SHEET/CHART AUDIT TOOL

Name _____ ID _____ Birthdate _____/_____/_____

Type of Diabetes: ☐Type 1 ☐Type 2 ☐Gestational ☐Other Date of Dx: _____/_____/_____

SBGM: ☐Yes ☐No Treatment (check all that apply): ☐Insulin ☐Oral Medication(s) ☐Diet ☐Physical Activity

*Instructions: Please indicate date of exam/test, "A" for abnormal or "N" for normal, as well as the actual results, when appropriate (e.g., lab value), "D" if done elsewhere, and "R" if referred. Write additional explanations in the patient's clinical notes.*

| General Recommendations for Care | date/results | date/results | date/results | date/results | date/results | date/results |
|---|---|---|---|---|---|---|
| Review management plan *Type 1: every 3 months Type 2: every 3-6 months* | | | | | | |
| Review physical activity *each visit* | | | | | | |
| Weight | | | | | | |
| Height | | | | | | |
| BMI | | | | | | |
| **Self-Management Education** | | | | | | |
| *At diagnosis, then every 6-12 months or more as needed* | | | | | | |
| **Medical Nutrition Therapy** | | | | | | |
| *At diagnosis or first referral to RD: 3 to 4 visits, completed in 3 to 6 months. Then1-2 hours annually.* | | | | | | |
| **Glycemic Control** | | | | | | |
| A1C test *every 3-6 months* | | | | | | |
| Review A1C target goal *each visit* | | | | | | |
| **Cardiovascular Care** | | | | | | |
| Fasting lipid profile *Children: after age 2 but before age 10, repeat annually if abnormal; Adults: annually* | | | | | | |
| Total Cholesterol | | | | | | |
| TG | | | | | | |
| HDL | | | | | | |
| Non-HDL | | | | | | |
| LDL | | | | | | |
| Blood pressure *each visit* | | | | | | |
| Tobacco use status *each visit* | | | | | | |
| Tobacco cessation referral *if indicated* | | | | | | |
| Aspirin therapy *if indicated* | | | | | | |
| **Kidney Care** | | | | | | |
| Albumin to creatinine ratio *Type 1: begin with puberty or after 5 yrs duration, then annually Type 2: at dx, then annually* | | | | | | |
| Protein to creatinine ratio *annually after microalbumin > 300 mg/24 hrs.* | | | | | | |
| Serum creatinine for eGFR *annually* | | | | | | |
| ACE/ARB therapy | | | | | | |
| **Eye Care** | | | | | | |
| Dilated eye exam *Type 1: If age > 10 years, within 3-5 years of onset, then annually Type 2: At diagnosis, then annually* | | | | | | |
| **Neuropathies and Foot Care** | | | | | | |
| Inspect bare feet and stress self-exam *each visit* | | | | | | |
| Comprehensive lower extremity exam *annually* | | | | | | |
| **Oral Care** | | | | | | |
| Inspect gums and teeth *each visit* | | | | | | |
| Refer to dentist *every 6 months* | | | | | | |
| **Emotional and Sexual Health Care** | | | | | | |
| List: _____ | | | | | | |
| List: _____ | | | | | | |
| **Immunizations** | | | | | | |
| Influenza *annually* | | | | | | |
| Pneumococcal *once; revaccination per ACIP* | | | | | | |
| **Preconception and Pregnancy Care** | | | | | | |
| Assess contraception/discuss family planning *at diagnosis and each focused visit during childbearing yrs* | | | | | | |
| Preconception consult *3-4 months prior to conception* | | | | | | |
| Screen for type 2 diabetes post-GDM | | | | | | |