DIABETES initial visit

Patient Name: _____ Referring FD/Endo: _____ Type 1 / 2 / GDM / PreDM **X** ___ yr

Reason For Referral	

Complications/Comorbidities		**Data/Labs**
□ CVD	□ Nephropathy	Family MD _____
□ HTN	□ Neuropathy	Last A1C _____ Date: _____
□ Dyslipidemia	□ Retinopathy	Relevant Abnormal Labs: _____
□ Overweight/Obesity	□ Foot Disorders	_____
□ Psychosocial (anxiety,depression,financial)	□ ED	□ Logbook/Meter Reviewed
	□ _____	□ Previous Education

Risk Factors	
Smoking	Smoker _____ /day | Non-Smoker | Ex- Smoker - year quit _____
Alcohol	Y| N _____ drinks / day | week

Current Medications

Oral Medication	Directions	Insulin	Directions
Metformin | Glumetza	_____	Humalog | Humalog U200	_____
Glyburide | Diamicron | Diamicron MR	_____	NovoRapid | Apidra	_____
GlucoNorm	_____	Humulin R | Toronto	_____
Avandia | Actos	_____	Humulin N | Novolin NPH	_____
Januvia | Onglyza | Trajenta	_____	Lantus | Levemir | Toujeo	_____
Victoza | Byetta | Saxenda	_____	Premixed	_____
Invokana | Forxiga | Empa	_____	Other	

Is patient taking diabetes medications as directed? _____

Safety

Hypoglycemia Is patient experiencing lows? Y| N Frequency: _____ Does patient have hypoglycemia unawareness? Y | N Do they require a glucagon prescription? Y | N ☐ Handout reviewed and provided	**Driving** Does patient drive? Y| N ☐ Handout reviewed and provided
Blood Glucose Meter Does patient have BG meter? Y| N When was their meter last replaced or tested for accuracy? _____ Was new meter provided to patient today? Y| N How often is patient testing BG? _____ /day	**Sick Day Management** ☐ Handout reviewed and provided

Assessment	Notes/ Recommendations
Activity Dose the patient participate in routine activity? Y| N Notes: ☐ Discussed importance / benefits of activity	Reviewed: ☐ Diabetes pathophysiology ☐ Medication mechanisms of action ☐ SMBG timing and frequency ☐ Carbohydrate counting □ Handout reviewed and provided ☐ Meter start instructions ☐ Insulin injection technique review ☐ Insulin start checklist (see attached) ☐ GLP-1 start checklist (see attached)
Diet / Stress / Other	☐ See attached Goals & Recommendations Sheet
	Monitoring/ Follow-up ☐ **None required** **Phone:** ☐ _____ days ☐ _____ weeks **Clinic:** ☐ _____ weeks ☐ _____months **Email:** ☐ consent obtained ☐ _____weeks **Referral to Group Classes?** Y | N

Educator: _____ Date: _____