

DIABETES new GLP-1 start

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| Patient Label |
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Referring Physician: _____

Date: _____

| Medications | | | |
|---|--|------------------|------------------------------|
| <input type="checkbox"/> Victoza <input type="checkbox"/> Saxenda <input type="checkbox"/> Adlyxine <input type="checkbox"/> Trulicity <input type="checkbox"/> Ozempic <input type="checkbox"/> Other: | | | Previous use of GLP-1? Y N |
| Oral DM Medications to CONTINUE : | | | |
| Dose Adjustments: | | | |
| Oral DM Medications to DISCONTINUE : | | | |
| Insulin(s): | | Dose Adjustment: | |

| Counseling Check List | |
|--|--|
| <input type="checkbox"/> Indication for GLP-1 (Target BG and A1C goals) | Practice <input type="checkbox"/> Patient did not want to practice in clinic <input type="checkbox"/> Patient practiced injection: NO med delivered <input type="checkbox"/> Practiced actual injection: _____mg delivered |
| <input type="checkbox"/> Mechanism of Action | |
| <input type="checkbox"/> SBGM (frequency and recording) | |
| <input type="checkbox"/> Appropriate titration if no s/e | |
| <input type="checkbox"/> Explain Symptoms <ul style="list-style-type: none"> <input type="checkbox"/> Very Common: nausea, diarrhea <input type="checkbox"/> Common: hypoglycemia, headache, vomiting, burping, indigestion, inflamed stomach, GERD, painful/swollen abdomen, constipation, flatulence <input type="checkbox"/> Advised to call clinic if persistent n/v | Handouts Provided <input type="checkbox"/> GLP-1 start instruction <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Injection Technique <input type="checkbox"/> Sharps |
| <input type="checkbox"/> Pen Review and priming | |
| <input type="checkbox"/> Site selection and rotation; injection technique | |
| <input type="checkbox"/> Changing needles/pen tips and sharps disposal | |
| <input type="checkbox"/> Temperature and Storage | |
| <input type="checkbox"/> Need for further diabetes, dietary, therapeutic or lifestyle change education? Y N | |
| <input type="checkbox"/> GLP-1 samples provided? Y N | |

| Notes |
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| Follow Up | | | |
|---------------------|------------------------------------|-------------------------------------|-------------------------------|
| Clinic: | <input type="checkbox"/> ___ Weeks | <input type="checkbox"/> ___ Months | <input type="checkbox"/> NONE |
| Phone/Email: | <input type="checkbox"/> ___ Days | <input type="checkbox"/> ___ Weeks | <input type="checkbox"/> PRN |

Educator: _____

Date: _____