Addressograph

Diabetes Patient Care Flow Sheet

Name	**KS Number**	**Type of Diabetes** Type 1☐ Type 2☐	**Date of Birth**	**Date of diagnosis**

Risk factors, comorbidities				**Self Management**		
☐Hypertension	☐Dyslipidaemia	☐CKD	☐Foot disease	Patient Goals:_____ _____		
☐Coronary Artery disease	☐Peripheral vascular disease		☐Erectile dysfunction	Height:	Weight target:	Target BMI
Lifestyle changes				Weight management discussed ☐		
Smoking: No☐ Yes☐ Cessation discussed☐				Education on complications ☐		
Alcohol intake: _____ Units/Week Advise given ☐				Nutrition education ☐ Date_____		

Visits (every 3 months)

Date	**BP**	**Wt (kg)**	**BMI**	**HBA1c Target__**	**Notes (goals, clinical status)**	**Hypo-glycaemia**	**DM therapy/ CV agents** ACEi/ARB/Statin /ASA as indicated

Review home glucose monitoring: Target pre-meal 4-7mmol/L, 2 hours post meal 5-10mmol/L

Screen for diabetic complications annually or as indicated

Nephropathy			**Neuropathy**	**Retinopathy**
Date	ACR	eGFR	Check feet for lesions and sensation(10g monofilament or 128Hz tuning fork) Check for Pain, ED, GI symptoms	Eye exam: Date:_____ Findings:____ _____
			Date: Findings:	Plan:
			Date: Findings:	Ophthalmologist:

Vascular protection	**Lipid Targets:**			**CAD assessment**
☐Statin if ≥40yrs or 30yrs with DM >15yrs or end organ damage	Date	Lipid levels	Plan	ECG
☐ACEi/ARB if ≥55yrs OR end organ damage (even in absence of HTN)				Stress ECG
				Other

See reverse side for care objectives and targets

Home glucose monitoring	Ensure patient can use glucometer, interpret results and modify theray as needed. Develop glucose monitoring schedule with patient and review records	Premeal(mmol/L**) 4-7 for most patients.** 2hr post meal **5-10 for most patients. 5-8** if not achieving A1C
Blood glucose control	**A1c every 3 months**. If well controlled consider 6 monthly measurements	A1c **<7** for most patients. Can be adjusted based on life expectancy, reurrent severe hypoglycaemia, extensive CAD, comorbidities
Hypoglycaemia	Enquire about hypoglycaemia each visit. Discuss recognition, treatment and risk /benefit of tight pharmacologic management	Avoidance of hypoglycaemia especially in elderly, those with hypoglycaemia unawareness, and those for less stringent control
Hypertension	BP at **diagnosis and every visit**	**<130/80**
Waist Circumference	Indicator of abdominal fat	Central obesity defined as: WC **M>94cm W >80cm** African WC M**>90cm W >80cm** Asians
Body Mass Index	Calculate BMI (mass in kg/HT in meters^2)	Target BMI **18.5-24.9**
Nutrition	Nutritional therapy by registered dietician as part of education on self management	Meet nutritional needs and better glycaemic control
Physical Activity	Encourage aerobic and resistance exercise	Aerobic **>150min/week** Resistance **3 sessions /week**
Smoking	Encourage cessation at each visit if applicable	**Smoking cessation**
Alcohol	Encourge safe alcohol intake if applicable. (Regular drinking =every day or most days of the week.)	Men should not regularly drink **>3 units/day** Women should not regularly drink **>2units/day**
Chronic Kidney disease	CKD: Random ACR with **proteinuria**(2 out of 3 samples over 3 months) and assessment of **eGFR** derived from **serum creatinine**. **T1DM** screen at 5years duration then annually if no CKD. **T2DM** at diagnosis and yearly if no CKD	**Normal ACR <2.0mg/mmol** **Normal eGFR >60ml/min**
Retinopathy	**T1DM** screen at 5 years from diagnosis then annually **T2DM** at diagnosis and 1-2 year after if no retinopathy present. Intervals tailored to severity of retinopathy. Screening should be done by a specialist	Early detection and treatment
Neuropathy/ Foot examination	T1DM screen at 5 years duration then annually T2DM at diagnosis and yearly. Use 10g monofilament or 128Hz tuning fork at dorsum of great toe. In foot examination look for structural abnormalities, vascular disease, ulceration and infection	Early detection and treatment. If neuropathy present give foot care education, specialised footwear, smoking cessation. If ulcer present, manage by MDT with expertise
Coronary artery disease (CAD)	**CAD risk assessment periodically:** CV history, lifestyle duration of DM, sexual function, abdominal obesity, BP, pulses bruits, retinopathy, glycaemic control, lipid profile, eGFR, ACR. **Baseline ECG and every 2 years if** >40years, >30years with duration >15years, end organ damage, cardiac risk factors	**Vascular protection:** first priority in prevention of diabetes complications is **reducton of CV risk by vascular protection** through a multifaceted approach **Statin if:** >40yrs OR OR >30yrs with DM >15yrs OR macrovascular OR microvascular disease **ACEi/ARB if:** >55yrs OR macrovascular OR microvascular disease
Dyslipidaemia	**Fasting lipid levels (TC, HDL, TG and calculated LDL)** at diagnosis and yearly if treatment not initiated. More frequent testing if treatment commenced	Targets for those who need therapy: **Primary target:LDL <2.0 or >50% reduction** **Alternate primary target: non HDL-C <2.6mmol/L**
Care objectives: People with diabetes will have better outcomes if 1. They are identified early 2. Self management is encouraged with use of multidisciplinary approach to attain care objecitves 2. Diabetes focused		

visits are scheduled 4. Diabetes flow charts are used with systematic recall