



DIABETES STANDARD OF CARE FLOW SHEET

Patient Name: _____ Physician Name: _____

Date of Birth: _____ Physician Phone: _____

WellCare/HealthEase/Staywell Member #: _____

INTERVENTIONS	DATE/RESULT	DATE/RESULT	DATE/RESULT	DATE/RESULT
Blood pressure goals <130/80 mm Hg				
Weight (lb or kg)				
Height				
Visual foot exam (each visit)				
Retinal eye exam (annually) Date: Result: Physician name:				
Renoprotective therapy (ACE or ARB)				
Aspirin therapy If age >40 or high risk for CVD				
Sensory foot exam (annually)				
LAB VALUES				
LDL profile (annually) LDL C <100				
HDL >40 mg/dL (male) HDL >50 mg/dL (female)				
Triglycerides <150 mg/dL				
Total cholesterol mg/dL (<200mg/dL desirable)				
HBA1c (every 3-6 months) <7.0%				
Kidney function eGFR; or <input type="checkbox"/> 24-hour cr. clearance; or <input type="checkbox"/> Microalbumin/creatinine ratio; <input type="checkbox"/> or Random spot urine <input type="checkbox"/>				
VACCINATIONS				
Flu vaccine (annually)				
Pneumonia vaccine				
PATIENT TEACHING				
Preconception counseling				
Smoking cessation counseling				
Exercise program				
Nutrition & weight management				
Medication/insulin counseling				
Self blood glucose monitoring				
Self foot exam				
Other				

Annual Service