

Diabetes Management Record

Name:	DOB:	M/F	Ethnicity:
Allergies:	Advance Directive Discussion Date:		
	Copy of Advance Directive in Chart: Y/N		

Date of Diagnosis: _____

BMI Calculation	Date/BMI	Date/BMI	Date/BMI	Date/BMI	Date/BMI
Date	Diabetic Problem List / Complications				
Consultations/Referrals		Date & Referrals	Date & Referrals	Date & Referrals	Date & Referrals
Endocrinology / Diabetology					
Name:					
*Ophthalmology					
Name:					
Podiatry					
Name:					
*Nephrology					
Name:					
Diabetic Teaching Center					
Name / Location:					
Other:					
Maintenance		Date / Results	Date / Results	Date / Results	Date / Results
*HbA1C (Every 3 months)					
*Microalbumin (Every year)					
*Dilated Retinal Eye Exam by OPH (Every year)					
Lipids: Total Cholesterol, LDL/HDL, Triglycerides (Every year) Record LDL Date & Value					
Blood Pressure Reading (Check every visit, reading must be <140/90)					
Other:					
Prevention		Date	Date	Date	Date
Pneumonia Vaccine (Once, or as clinically indicated)					
*Flu Vaccine (q year)					
Education	Date	Date	Date	Date	Date
ADA Guidelines					
Nutrition					
Exercise					
Foot Care					

***HEDIS® Requirement** – HEDIS® is a registered trademark of the National Committee for Quality Assurance. Quality reviews are performed annually on randomly selected patients. Keeping this form updated will reduce the need for excess medical record copying during the HEDIS Medical Record Review. HEDIS requires documentation of Blood Pressure Recordings and Medication Management.