# Sample Diabetes Care Flow Sheet

| **Name**: | **Type of diabetes**: Type 1 □ Type 2 □ Other □ | **Date of birth**: | **Age at diagnosis**: |
|---|---|---|---|

## Comorbidities, Risk Factors Date:

□ Hypertension (target <130/80)

□ Dyslipidemia

| | |
|---|---|
| □ CVD | □ Smoking (date stopped) |
| □ HF | □ Alcohol/ other substances: (assess/discussed) |
| □ CKD | □ Mental Health Diagnosis |
| □ Stroke | □ Foot disease |
| □ PAD<br>□ ED<br>□ PCOS | □ Retinopathy<br>□ Family History |

## Self-management (discuss and share decisions)

Priorities and Goals:_____

Possible Barriers to Self –management _____

_____

Self-management Education _____

□ Weight management:

Baseline weight: Wt. . Ht: _____

Baseline BMI: ___ (Healthy BMI 18.5–24.9)

□ Physical activity (150 min/week- aerobic/ resistance 2-3 times a week)

_____

□ Glucose meter/lab comparison

□ Patient care plan ( including pregnancy planning) □ Driving Guidelines

## Visits (every 3 to 6 months)

| Date | BP | Weight as required | A1C (Target ≤ 7% or ____) | Notes (concerns, goals, clinical status) | Hypoglycemia | DM Medication Baseline and Changes: Allergies, side effects, contraindications. Consider: ASA, ACEI, ARB, antihyperglycemics as indicated |
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**Review SMBG records. Target: premeal 4–7 mmol/L; 2-hour postprandial 5–10 mmol/L ( 5-8 mmol/L if A1C not at target)**

## Screen for diabetes complications annually or as indicated

**Nephropathy: CKD: eGFR< 60 ml/min or ACR >2 mg/mmol**

| Date | ACR | eGFR |
|---|---|---|
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**□ Neuropathy**

- Check feet for lesions and sensation (10-g monofilament or 128 Hz tuning fork)
- Check for pain, ED, GI symptoms

Date: Findings:
Date: Findings:
Date: Findings:

**□ Retinopathy**

Annual eye exam:
Date:
Date:

Ophthalmologist/Optometrist:

_____

**For vascular protection (see back for details):**

□ Statins if ≥ 40 yrs Or > 30 yrs and >15 yrs duration or end organ damage

□ ACE /ARB if macro or micro vsc. disease or > 55 yrs with 1 CVD risk factor

□ SGLT2i or GLP1-RA: Consider if ASCVD, HF, CKD

**CVD Assessment:**

□ ECG (see back)

Stress ECG:_____

Other:

**□ Lipids Targets**: If indicated to treat:

**Primary target: LDL <2 mmol/L**

| Date | Medication | LDL-C | HDL-C | TG | (Non-HDL-C) | (Apo B) |
|---|---|---|---|---|---|---|
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**□ Vaccinations**

Annual influenza
Date:
Date: _____

Pneumococcus
Date:

**See reverse side for care objectives and targets**

| Care | Objective | Target |
|---|---|---|
| **Self-monitoring of Blood Glucose** | Ensure proper use of glucose meter, flash meter, or CGM. Interpret results and modify treatment as needed.<br>Develop blood glucose monitoring schedule using goals and shared decisions. Review records. | Premeal (mmol/L) = **4.0-7.0 for most people**<br>2hr Postmeal (mmol/L)<br>**5.0 -10.0 for most people with DM**<br>**5.0 -8.0** if not achieving A1C target |
| **Blood Glucose Control** | Measure **A1C every three months** for most adults<br>Consider testing at least every 6 months in adults during periods of treatment and lifestyle stability when glycemic targets have been consistently achieved. Understand when A1C is not accurate. ( eg CKD).<br>Check accuracy of meter with laboratory annually | A1C ≤ **7.0 % for most people with DM**<br>Individualized based on patient and agent Characteristics.<br>Simultaneous fasting glucose/meter lab comparison within **20%.** |
| **Regular Review Adjust Treatment** | Regular review of clinical status:<br>Advance / adjust AHA if not at target and identify those with ASCVD, HF, CKD who may require adjustments even is at target | **Add or substitute AHA with cardiorenal benefit ( SGLT2i / GLP1RA). Even if A1C is at target** |
| **Nutrition** | Encourage individualized nutritional therapy (by a registered dietitian) as an integral part of treatment and self-management (can reduce A!C by 1-2%). If overweight or obesity is present, strategies that include energy restriction to achieve a modest weight loss of 5% to 10% of initial body weight are a primary consideration. | To attain and maintain a healthy or lower body weight for the long term, to prevent further weight gain or to prevent weight regain while meeting nutritional needs. |
| **Physical Activity** | Discuss and encourage aerobic and resistance exercise.<br>Evaluate those with possible CVD or microvascular complications undertaking exercise substantially more vigorous than brisk walking | Aerobic: ≥ **150 minutes /week**<br>Resistance: **3 sessions/week** |
| **Body Mass Index** | Calculate BMI (mass in kilograms/height in metres2) | Healthy body weight target: **BMI: 18.5 – 24.9** |
| **Smoking** | Encourage smoking cessation at each visit; provide support as needed | **Smoking cessation** |
| **CVD Risk Identification and Protection** | Review for presence of CVD disease<br><br>**Conduct CVD risk assessment periodically** : CV history, lifestyle, duration of DM, sexual function, abdominal obesity, lipid profile, BP, reduced pulses, bruits, glycemic control, retinopathy, eGFR, ACR.<br><br>Resting ECG every 3-5 years if any of :<br>age > 40 years, duration of DM>15yrs.+>30yrs,end organ damage( microvasc. or CVS)),>1 CV risk factor. | **Vascular Protection:** First priority in prevention of diabetes complications is **reduction of cardiovascular risk by vascular protection** through a comprehensive multifaceted approach<br>**All people with DM:** optimize: BP, glycemic control and healthy behaviours<br>**Statin if**: age ≥ 40y or macrovascular disease OR<br>if <40y + microvascular disease or long duration of DM (DM>15yr and age >30y)<br>**ACE-I or ARB if CVD or microvsc. disease or >55 yrs with 1 CVD risk factors**<br>**Use of AHA ( SGLT2i or GLP1-RA)** EVEN if at A1C target for those with ASCVD, CKD,HF,>60yrs.+CVrisk factors |
| **Hypertension** | Measure BP at **diagnosis and at every diabetes clinic visit** | **<130/80** |
| **Dyslipidemia** | **Fasting lipid levels (TC, HDL, TG and calculated LDL)** at diagnosis, then yearly if treatment not initiated. More frequent testing if treatment initiated. | Lipid targets for those who need therapy:<br>**Primary target : LDL < 2.0 mmol/L or >50% reduction. Alternate Primary target: apo B < 0.8 g/L or non-HDL-C < 2.6 mmol/L** |
| **Retinopathy** | **Type 1 diabetes** Screen 5 years after diagnosis, then rescreen annually<br>**Type 2 diabetes** Screen at diagnosis and 1- 2 years after initial screening if no retinopathy is present. The interval for follow-up assessment should be tailored to the severity of the retinopathy.<br>Screening conducted by an experienced eye care professional | Early detection and treatment |
| **Chronic Kidney Disease** | Identification of CKD requires screening for **proteinuria** using random urine **ACR** (2 out of 3 samples over 3 mths.) and **assessment of renal function** using a serum creatinine converted to **eGFR.**<br>**Type 1 diabetes** Screen at 5 years duration and then annually if no CKD<br>**Type 2 diabetes–** Screen at diagnosis and then yearly if no CKD<br>If CKD present, ACR and eGFR should be done at least every 6 months | **ACR (mg/mmol) < 2.0**<br>**eGFR > 60 mL/min** |
| **Neuropathy/ Foot examination** | **Type 1 diabetes**– Screen 5 years duration and annually<br>**Type 2 diabetes** – Screen at diagnosis, then annually<br>Screen for neuropathy with 10-g monofilament or 128 Hz tuning fork at dorsum of great toe. In foot exam look for: structural abnormalities, neuropathy, vascular disease, ulceration, infection | Early detection and treatment.<br>If neuropathy present: require foot care education, specialized footwear, smoking cessation. If ulcer present: manage by multidisciplinary team with expertise |
| **Immunizations** | Recommend annual influence vaccination. Recommend pneumo-vax 23 | |
| **Populations with Mental Health Concerns** | Liaise with mental health-care professionals where necessary to ensure appropriate care plans are developed that include psychosocial interventions and glycemic control | Mental health treatments may improve diabetes outcomes |

**Care Objectives: People with diabetes will have better outcomes if primary care providers 1) identify people with diabetes in their practices 2) assist them by incorporating the suggested care objectives; 3) schedule diabetes-focused visits; 4) use diabetes flow sheets and systematic recall for visits**