Sample Diabetes Patient Care Flow Sheet for Adults

Name Date of birth	Type 1 ❏ Type 2 ❏ Age at diagnosis

Care objectives (risk factors, comorbidities)	*Self-management (discuss with patient)*

❏ Hypertension (target <130/80 mm Hg)
❏ Dyslipidemia
❏ CAD   ❏ Smoking _____ (date stopped)
❏ PAD   ❏ Alcohol _____ (assess/discussed)
❏ CKD   ❏ Mental health diagnosis
❏ PCOS   ❏ Foot disease
❏ ED   ❏ Retinopathy
	❏ Refer to diabetes teaching team _____ (date)
	❏ Weight management:
	   Wt: _____ Ht: _____ BMI: _____ (normal: 18.5–24.9 kg/m²)
	   Target wt: _____ WC: _____ (M <102 cm; F <88 cm)
	❏ Physical activity (≥150 min/week): _____
	❏ Glucose meter/lab comparison
	❏ Patient care plan (including pregnancy planning)

Visits (3 to 6 months)

Date	BP	Wt	A1C (Target ≤7%)	Notes (goals, clinical status)	Diabetes medication baseline: Allergies, side effects, contraindications. Consider ACEI, ARB, statin, ASA as indicated

Review SMBG records. Target: preprandial 4–7 mmol/L; 2-hour postprandial 5–10 mmol/L (5–8 mmol/L if not achieving A1C target)

Screen for diabetes complications annually, or as indicated

Nephropathy

Date	ACR target: M <2.0, F <2.8	eGFR/CrCl target: >60

Neuropathy

❏ Check feet for lesions and sensation
   (10-g monofilament, 128 Hz tuning fork)
❏ Check for pain, ED, GI symptoms
Date: _____ Findings: _____
Date: _____ Findings: _____
Date: _____ Findings: _____

Retinopathy

❏ Annual eye exam
   Date: _____
   Date: _____
Ophthalmologist/optometrist:
_____

CAD assessment

❏ Not high risk   ❏ High risk
   Definition M ≥45 y, F ≥50 y
   or has ≥1 of the following:
   macrovascular disease; microvascular disease;
   multiple risk factors (esp. family history);
   1 extreme risk factor; duration of diabetes
   >15 y and age >30 y

Resting ECG: _____

Exercise stress test: _____

Other: _____

Lipids   Targets for those at high risk for CAD
Primary target: LDL-C ≤2.0 mmol/L
Secondary target: TC/HDL-C <4.0

Date	TC	LDL-C	TC/HDL-C	TG	Medications

Vaccinations

❏ Annual influenza
   Date: _____
   Date: _____
❏ Pneumococcus
   Date: _____

SEE REVERSE FOR CARE OBJECTIVES AND TARGETS

Care	Objective	Target
Self-monitoring of blood glucose	• Reinforce patient's responsibility for regular monitoring as appropriate • Ensure patient can use glucose meter, interpret SMBG results and modify treatment as needed • Develop an SMBG schedule with patient and review records	Preprandial (mmol/L) **4.0–7.0 for most patients** 2-hour postprandial (mmol/L) **5.0–10.0 for most patients** **5.0–8.0 if not achieving A1C target**
Blood glucose control	• Measure **A1C every 3 months** for most adults • Consider testing at least every 6 months in adults during periods of treatment and lifestyle stability, and when glycemic targets are being consistently achieved	A1C **≤7.0% for most patients** See "Targets," p. S29*
Blood glucose meter accuracy	• Compare meter results with laboratory measurements at least **annually**, and when indicators of glycemic control do not match meter	Simultaneous fasting glucose/meter lab comparison within **20%**
Hypertension	• Measure BP at **diagnosis of diabetes and at every diabetes clinic visit**	**<130/80 mm Hg**
Waist circumference	• Measure as an indicator of abdominal fat	Target WC: M <102 cm, F <88 cm (see ethnic-specific values in "Management of Obesity in Diabetes," p. S77)*
Body mass index	• Calculate BMI: mass in kg/(height in m)²	Target BMI: **18.5–24.9 kg/m²**
Nutrition	• Encourage nutrition therapy (by a Registered Dietitian) as an integral part of treatment and self-management (can reduce A1C by 1–2%)	Meet nutritional needs by following *Eating Well with Canada's Food Guide*
Physical activity	• Discuss and encourage aerobic and resistance exercise • Consider exercise ECG stress test for previously sedentary individuals at high risk for CAD planning exercise more vigorous than brisk walking	Aerobic: **≥150 minutes/week** Resistance: **3 sessions/week**
Smoking	• Encourage patient to stop at each visit; provide support as needed	**Smoking cessation**
Retinopathy	• **Type 1 diabetes:** Screen 5 years after diagnosis, then rescreen annually • **Type 2 diabetes:** Screen at diagnosis, then every 1–2 years if no retinopathy present • Screening should be 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 and assessment of renal function** using a serum creatinine converted to **eGFR** • **Type 1 diabetes:** In adults, screen after 5 years duration of diabetes, then annually if no CKD • **Type 2 diabetes:** Screen at diagnosis, then annually if no CKD • If CKD present, perform ACR and eGFR at least every 6 months	ACR (mg/mmol) Normal: **M <2.0; F <2.8** Microalbuminuria: **M 2.0–20.0, F 2.8–28.0** Macroalbuminuria: **M >20.0, F >28.0** **CKD if eGFR ≤60 mL/min**
Neuropathy/ foot examination	• **Type 1 diabetes:** Screen 5 years after diagnosis, then rescreen annually • **Type 2 diabetes:** Screen at diagnosis, then annually • 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, arterial disease, ulceration, infection	**Early detection and treatment** If neuropathy present: foot care education, specialized footwear, smoking cessation If ulcer present: manage by multidisciplinary team with expertise

CAD assessment	• **Conduct CAD risk assessment periodically:** CV history, lifestyle, duration of diabetes, sexual function, abdominal obesity, lipid profile, BP, reduced pulses, bruits, glycemic control, retinopathy, eGFR, ACR
	• **Measure baseline resting ECG, then every 2 years if:** age >40 years, duration of diabetes >15 years, symptoms, hypertension, proteinuria, bruits or reduced pulses
	• **High-risk categories include:**
	  • Men ≥45 years, women ≥50 years or
	  • Men <45 years, women <50 years with ≥1 of: macrovascular disease, micro-vascular disease (especially retinopathy, nephropathy), multiple additional risk factors (especially family history of premature coronary or cerebrovascular disease in 1st-degree relative), extreme single risk (e.g. LDL-C >5.0 mmol/L, systolic BP >180 mm Hg) or duration of diabetes >15 years and age >30 years
		Vascular protection: first priority in prevention of diabetes complications is **reduction of CV risk by vascular protection** through a comprehensive multifaceted approach:
		• All people with diabetes: optimize BP, glycemic control and lifestyle (weight, exercise, smoking)
		• People with diabetes and at high risk of CV event, additional interventions: ACE inhibitor/ARB antiplatelet therapy (as indicated) and lipid-lowering medication (primarily statins)

Dyslipidemia	• **Measure fasting lipid levels (TC, HDL-C, TG and calculated LDL-C)** at diagnosis of diabetes, then every 1–3 years as clinically indicated. Test more frequently if treatment initiated	Lipid targets for those at high risk for CAD: • **Primary target: LDL-C ≤2.0 mmol/L** • **Secondary targe t: TC/HDL-C <4.0**

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