SECTION 2
FLOWSHEETS

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DIABETES MELLITUS
MINIMUM PRACTICE RECOMMENDATIONS
FLOW SHEET

NAME: _____ **ID# or SSN:** _____

SEX: M_____ **F**_____ **D.O.B.** _____/_____/_____

Record date of visit at beginning of column and results of any ordered test in the appropriate box below.

EXAMINATION / TEST	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
COMPLETE History & Physical Exam (including risk factors, exercise, and diet history) Schedule: Initial and annually at discretion of clinician					
Weight Schedule: Every visit					
Blood Pressure Systolic <130 mm Hg Diastolic < 85 mm Hg Schedule: Every visit					
Dilated Funduscopic Eye Exam Schedule: TYPE 1: annually beginning 5 years from onset TYPE 2: initially, then annually after 4 years NOTE: If retinopathy, persistently elevated glucose, or proteinuria is present, then annually					
Foot Exam (Visual inspection for lesions, calluses, and infections without shoes and socks) Schedule: Every visit					
Dental Inspection Schedule: Every visit					
Glycosylated Hemoglobin Schedule: Every 6 months					
Lipid Profile <130 mg/dl LDL >35 mg/dl HDL <200 mg/dl Triglycerides Schedule: Annually					
Microalbuminuria Random urine for microalbuminuria or urinary albumin <30 mg/24 hours Schedule: Annually					
Diabetes Education Schedule: Initial and at clinicians's discretion					
Nutrition Counseling Schedule: Initial and at clinician's discretion					
Review of the Management Plan: See Back of Page Schedule: Every 6 months					

DIABETES MELLITUS
COMPONENTS OF
DIABETIC MANAGEMENT PLAN

DIABETIC MANAGEMENT PLAN COMPONENTS*	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Nutrition and Weight Evaluation					
Medications					
Exercise Regimen					
Glucose and Lipid Control					
High Risk Behaviors (e.g., smoking, alcohol)					
Frequency of Hypoglycemia					
Compliance with Aspects of Self-Care (degree of adherence to the self-management plan from the last visit, i.e., diet, medication use, exercise plan, etc.)					
Assessment of Complications					
Follow-up of Referrals					
Psychological/psychosocial Adjustment					
General Knowledge of Diabetes					
Self-Management Skills (including monitoring, sick day management)					

*Record date of visit at beginning of column and place a check mark in appropriate space below date for each item reviewed.

MEDICATIONS**	Current Dosage	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

**Record medication name and current dosage in first two columns. Then, record date at beginning of column and place any dosage changes next to appropriate medication.

diabetes CHECKPOINTS ▶

This diabetes management guide is based on the American Diabetes Association's "Standards of Medical Care for Patients with Diabetes Mellitus." Use it as a reminder for exams or important tests, to simplify record keeping and as a way to continually improve care to all of your patients with diabetes.

Patient Name _____ Birth Date _____

ID/Insurance # _____ M F

Clinic/Physician _____

treatment topic	date : results	date : results	date : results	date : results
foot exam every visit				
ophthalmology/optometry referral/dilated retinal exam annually				
urinalysis annually				
test for microalbuminuria annually				
glycosylated hemoglobin quarterly: if changing regimen or poor control; 2 times/yr. if stable				
cholesterol annually				
triglycerides annually				
HDL annually				
LDL annually				
weight every visit				
diet assessment/instruction every visit				
patient education once or more/yr.				
BP every visit				
other _____				

frequency recommendations for stable diabetics; more frequent monitoring required for unstable diabetics

a collaborative quality improvement effort from: PEER REVIEW SYSTEMS

American Diabetes Association® Ohio Affiliate, Inc.

(last up-date 5/98)

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Diabetic Care Flow Sheet

Patient Name: _____ **Chart #:** _____

Directions:
- Date column and place your initials in appropriate item column when "done". If additional charting is indicated, please use standard clinic progress notes.
- Signature and Initials are required in the BACK of this form.
- Items with "*" are required for QA purposes.
- List Current Diabetic Medication on the Back of this form.

Date:										
• HbA1C (6 Months)	Results	Results	Results	Results	Results	Results	Results	Results	Results	Results
• Foot Exams (6 Months)										
• Retinoscopy (Annual)										
• Ophthalmologist if Retinoscopy Abnormal										
• Urine Protein Dipstick (Annual)										
• If Dipstick is Negative, a 24-hr. Urine for Microalbumin										
• Documentation of Home Glucose Monitoring										
Diabetes Medications Record on Back										
Diet										
Diabetic Education										
Flu Immunization (Annual)										
Pneumovax										
Other:										

Date	**Medication(s) (Name, Dosage, Route and Frequency)** ● Only medications related to diabetes need to be recorded here. ● If a medication is changed, draw a single line through the entry, date and initial, and enter the new medication. ***Do NOT write over the entry being changed.***	Initial

Signature and Initials	Signature and Initials

Oregon Diabetes Project – Draft Flowsheet for Encounter Data Collection

Pt. Name _____
Sex _____ DOB _____
ID# _____
Diabetes Type _____ Onset Date _____

Provider/Clinic Name _____
Address _____
Phone _____
ID #(s) _____

Optional Information:
Insulin _____ Oral Agent _____ Diet Only _____
Pneumouvax (date) _____ Revaccination _____

Of childbearing age? (if yes, see educ. sheet)
Allergies _____
Co-morbid conditions _____

Preventive Screening Services **Date**								
HbAlc Monitoring – Target: ≤8.0% ❑ Type 1-min. semiannually ❑ Type 2-min. annually								
Blood Pressure – Target: ≤130syst/≤85 dias Type 1 or Type 2 - min. semiannually								
ACE or Anithypertensive _____								
Microalbuminuria – Target: neg or <30mg/24-hr Type 1 (after 5 yrs) or 2 – annually ❑ n/a	❑ <30 ❑ >30	❑ <30 ❑ >30	❑ <30 ❑ >30	❑ <30 ❑ >30	❑ <30 ❑ >30	❑ <30 ❑ >30	❑ <30 ❑ >30	❑ <30 ❑ >30
Quantitative Albuminuria – Target: Set tx plan Assess if microalbuminuria is >30mg/24-hr ❑ n/a	❑ <300 ❑ >300	❑ <300 ❑ >300	❑ <300 ❑ >300	❑ <300 ❑ >300	❑ <300 ❑ >300	❑ <300 ❑ >300	❑ <300 ❑ >300	❑ <300 ❑ >300
Visual Foot Inspection – See exam sheet Type 1 (after 5 yrs) or 2 – each routine visit ❑ n/a	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes
Complete Foot Exam – See exam sheet ❑ n/a Type 1 (after 5 yrs) or 2 – annually / new abnormality	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes	❑ yes
Dilated Eye Exam – Target: neg for retinopathy Type 1 (after 5 yrs) or 2 – annually ❑ n/a	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.
Specialist Referral _____								
Lipid Screening – Target: LDL <130 mg/dL ❑ Type 1 or 2 and ≥ 18 yrs old – annually ❑ Type 1 or 2 with CAD – Per NCEP algorithms								
Lipid Lowering Agent _____								
Oral/Dental Screening – Target: neg for prob. Type 1 or Type 2 – annually	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.	❑ neg. ❑ pos.
Referred to Dentist _____								
Influenza Immunization – Target: yes Type 1 or 2 – annually ❑ n/a	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
ASA Prophy – Target: lo-dose ASA qd/qod ____mg ❑ Type 1 or 2 and > 40 yrs with risk factors ❑ Type 1 or 2 with CAD, CVD, PVD	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Patient Education – Target: as needed Per guidelines (see educ/counseling sheet)	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
Tobacco Use – Target: none ❑ Type 1 or 2 – non-user – annually ❑ Type 1 or 2 – user – each visit (see educ/counseling sheet)	❑ none ❑ user	❑ none ❑ user	❑ none ❑ user	❑ none ❑ user	❑ none ❑ user	❑ none ❑ user	❑ none ❑ user	❑ none ❑ user
Record Next Visit Date – circle needed services ❑ Have pt. mark their health record for next visit								

KEY to recording Diabetes Preventive Care Service Results

(1.) always denotes desired target result

HbA1c Monitoring	(1.) ≤8.0% or write in actual value (2.) >8.0%
Blood Pressure	(1.) ≤130/85 (target) or write in actual value (2.) > 130/85
Microalbuminuria	(1.) neg or <30 (mg/24 hrs) (2.) >30 n/a (not appropriate for this patient – has known nephropathy, or has had Type 1 less than 5 yrs.)
Quantitative Albuminuria	(1.) <300 (mg/24 hrs) (2.) >300 n/a (not appropriate for this patient – has known nephropathy)
Visual Foot Inspection ..... (record results/referral on separate form)	(1.) yes (inspection was performed) n/a (not appropriate for this patient – bilateral amputee, or has had Type 1 less than 5 yrs.)
Complete Foot Exam and Assessment (record results/referral on separate form)	(1.) yes (exam was performed) n/a (not appropriate for this patient – bilateral amputee, or has had Type 1 less than 5 yrs.)
Dilated Eye Exam ..... (record referral and follow-up)	(1.) neg (for retinopathy) (2.) pos n/a (not appropriate for this patient – has known retinopathy, blindness, or has had Type 1 less than 5 yrs.)
Lipid Screening (LDL)	(1.) ≤100 (mg/dL) or write in actual value (2.) <130 (3.) >130
Oral/Dental Screening ..... (record referral and follow-up)	(1.) neg (for tooth or soft tissue problems) (2.) pos
Influenza Immunization	(1.) yes (vaccine given) (2.) no (vaccine offered but patient refused) n/a (not appropriate for this patient – has a medical contraindication)
Aspirin Prophylaxis ..... (record dose and schedule)	(1.) yes (patient is taking as ordered) (2.) no (not taking as ordered) n/a (not appropriate for this patient)
Patient Education ..... (record details on separate form)	(1.) yes (ordered or provided) (2.) no (assessed – not needed at this time)
Tobacco Use Assessment ..... (if user—record counseling/referrals on separate form)	(1.) none (2.) user (uses any tobacco products)
Preconception Counseling	*(if appropriate, record details on separate form)*

If a Preventive Care Service is not assessed, leave the results section blank.

DIABETES CARE FLOW SHEET

Patient Name: _____

Social Security Number: _____

Date of Birth: _____ Type of Diabetes: I / II (circle one)

Gender: M / F (circle one) Age of Onset: _____

Smoker: Y / N (circle one)

Write the dates of service in the shaded area.
Place a check under the dates of service for the exams, labs, or interventions completed for each visit.

Dates of Service											
PHYSICAL EXAM											
BP (Goal: <130/85; Every Visit)											
Retinal Exam Performed (Yearly)											
Weight (Every Visit)											
Foot Exam (Every Visit: Vascular, Skin Condition, Sensation)											
LAB											
HbAlc (Quarterly for IDDM; PRN for NIDDM)											
Lipid Profile (Yearly: Chol, Tri, HDL, LDL)											
Urine Dipstick (Glucose, Ketones, Protein)											
Serum Creatinine (If Proteinuria Present)											
Complete Urinalysis											
Microalbuminuria (Yearly)											
INTERVENTION											
Self-Monitoring Logs Reviewed (Every Visit)											
Smoking Counseling											
Referred for Retinal Exam (Yearly)											
Referred to Diabetes Educator											
Referred to a Podiatrist											
Referred to Dietitian											
ACE Inhibitor											
Pneumovax Vaccine											
Influenza Vaccine											
CURRENT MEDS											
Insulin											
Oral Hypoglycemic											
Other:											
Other:											

Write the name of the physician, nurse practitioner, or physician's assistant in the "Dr/NP/PA:" box below.
Place initials in the box(es) to the right for those date(s) where care was given.

PROVIDER											
Dr/NP/PA:											
Dr/NP/PA:											
Dr/NP/PA:											
Dr/NP/PA:											

September 1996

Adapted from; American Diabetes Association. (1996). Standards of Medical Care for Patients with Diabetes Mellitus. *Diabetes Care.* 19:8-14. And Diabetes Control and Complications Research Group. (1993). The Effect of Intensive Treatment of Diabetes on the Development and Progressions of Long-Term Complications in Insulin-Dependent Diabetes Mellitus. *New England Journal of Medicine.* 329:977-986.

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Clinic Data Collection Tool for Diabetes

Enter the most recent dates of service noted in the chart. Date chart reviewed and your initials / / _____

Patient Name	DOB / /	MR#	Clinic (Location)
Provider Name	Diabetes Type (circle one): Unknown 1 2 Gestational Other	Insurance (circle one): Medicare Other _____ None (circle every insurance carrier, even the ones not being billed) HIC#: _____ (if Medicare)	

Dates of Lab Work	/ /	/ /	/ /
HbAlc Result			
Dates of Lab Work	/ /	/ /	
Lipid Results Total Cholesterol			
LDL			
(Circle Sex: Male Female) HDL			
Triglycerides			
Dates of eye REFERRAL	/ /	/ /	
Dates of dilated eye EXAM	/ /	/ /	
Dilated Eye Exam Result/Comments			
Dates of Test	/ /	/ /	/ /
Tests for Nephropathy			
Dip Stick for Protein (MACROalbumin)	Y/N	Y/N	Y/N
Spot Microalbumin/Creatinine Ratio	Y/N	Y/N	Y/N
24-hr. Protein	Y/N	Y/N	Y/N
24-hr. Creatinine Clearance	Y/N	Y/N	Y/N
24-hr. Microalbumin	Y/N	Y/N	Y/N
Dates Feet Checked	/ /	/ /	/ /
Foot Exam Results Neuropathy	Y/N	Y/N	Y/N
Pulses	Y/N	Y/N	Y/N
Skin	Y/N	Y/N	Y/N
Deformity	Y/N	Y/N	Y/N

Comments:

Mar. 1999, Diabetes Phase 2, version 2

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Arizona Managed Medicare Quality Enhancement Program

Clinical Quality Indicator Record for Diabetes

I. Demographics

1. Name: _____ (Last, First, Middle)

2. HIC#: _____ (Health Identification Claim #)

3. DOB: ____/____/____ (MM/DD/YY)

4. Race: CAUC BLK HIS ASN NAI Other (Circle One)

5. Type of Diabetes: I II Other (Circle One)

6. Age of Onset: _____ (Enter Age of Onset)

7. Gender: M F (Circle One)

8. Height (inches): _____

9. HMO Plan: _____

II. Comorbidities

(circle all that apply)

1. Cancer
2. Cerebrovascular Disease
3. CHF
4. COPD
5. Coronary Artery Disease
6. Hyperlipidemia
7. Hypertension
8. Peripheral Neuropathy
9. PVD
10. Renal Disease
11. Other

III. Physical Exam

Date	Blood Pressure (enter first 4 values obtained each quar ter)				Ace Inhibitor Y / N	Weight (lbs.)	I = Insulin O = Oral Agent D = Diet
	/	/	/	/			
	/	/	/	/			
	/	/	/	/			
	/	/	/	/			
	/	/	/	/			

Retinal Exam				Foot Exam			
Date	Examiner IM/FP/GP/ OPHTH/OPTOM/ Other	Retinopathy N = Normal A = Abnormal	Referred to Eye Care Professional Y / N	Date	Examiner IM/FP/GP/ Other	Results N = Normal A = Abnormal	Referred to Vascular Specialist (VS) or Podiatrist (P)

IV. LABORATORY

Glycosylated Hemoglobin (check appropriate range)					Lipid Profile Results Enter Value				Treatment D = Diet M = Medication B = Both
Date	6.0 – 6.9%	7.0 – 7.5%	7.6 – 8.5%	> 8.5%	CHOL	TRI	HDL	LDL	Enter D, M, or B

Protein Dipstick (check appropriate box)				Microalbumin (check appropriate box)		
Date	+	–	Ace Inhibitor Y = Yes N = No A = Already on C = Contraindicated	< 20 MG/L	> 20 MG/L	Ace Inhibitor Y = Yes N = No A = Already on C = Contraindicated

V. EDUCATION

(check appropriate box)

Date	Diet	Dietician Referral Y / N	Diabetic Medications	Glucose Testing	Exercise	Smoker Y / N	Anti-smoking Advice

Physician Signature

DIABREC.FRM
November 3, 1995

Patient Flow Chart/Diabetes

D.O.B: _____ NAME: _____ MEDICAL RECORD #: _____

DATE	NO.	PERMANENT PROBLEMS	MEDICATIONS/DIET
	1	❑ NIDDM or ❑ IDDM	DIET:
	2		
	3		
	4		
	5		
	6		
	7		
	8		
	9		
	10		
	11		
	12		
	13		
	14		
	15		
	16		
	17		
	18		
	19		
	20		

TESTS AND PROCEDURES					
A.		D.		H.	
B.		E.		I.	
C.		F.		J.	
		G.		K.	

ADVERSE DRUG REACTIONS			IMMUNIZATIONS	DATES						
DRUG	DATE	RXN	HEPATITIS							
			DPT							
			POLIO							
			MMR							
			dT							
			TETANUS TOXOID							
			TB SKIN TEST							
			INFLUENZA							
			PNEUMOVAX							

SIGNIFICANT FAMILY HISTORY	SIGNIFICANT SOCIAL HISTORY	PREVIOUS SURGERY
	EXERCISE	
	ETOH	
	CIG PPDx YRS	

PREVENTIVE CARE																					
	H&P																				
	DILATED EYE EX																				
	CR/CRCL																				
	MICROALBUMIN																				
	PAP SMEAR/PELVIC																				
	BREAST EXAM/MAMMO																				
	DIET EDUCATION																				
	OCCULT BLOOD																				
	PROSTATE/PSA																				
	GLY HGB																				
	BS																				
	CHOL/TG																				
	FOOT EXAM																				
	BP																				
	FSC																				
	CXR																				
	EKG																				

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Diabetic Progress Record

Patient Name _____ **Allergies** _____

Member Number _____ **Medications** _____

Date of Birth _____ _____

Service Date _____ _____

Routine Visit Date (should be at least quarterly for insulin dependent diabetics) _____

T_____ P_____ R _____ BP_____

HEENT

CHEST

HEART

ABDOMEN

EXTREMITIES

FOOT EXAM

- Vascular Status
- Skin Condition
- Sensation

Labs $HgbA_1c$ (should be at least quarterly for all diabetic patients receiving insulin and as necessary to assess therapy in other diabetic patients) Yes _____ No _____

BLOOD SUGARS Yes _____ No _____

Counseling DIET Yes _____ No _____ Referred _____

ANTISMOKING Yes _____ No _____ NA _____ Referred _____

Complete at Least One (1) Time Yearly Date Performed/Referred

DILATED EYE EXAM _____

KIDNEY FUNCTION _____

- Serum Creatinine _____
- Urine Protein _____

LIPID MONITORING _____

INFLUENZA IMMUNIZATION (prior to flu season) _____

Follow-up Visit: _____ Days _____ Weeks _____ Months

Physician's Signature: _____

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DIABETES CARE FLOWSHEET

PROJECT IN A BOX

Patient Name _____ Birth Date ____/____/____ Gender M___ F____

PAYER & PATIENT NUMBER:

Medicare _____

Medicaid _____

Other, please specify _____

CLINIC & PROVIDER:

Clinic _____

Location _____

Physician _____ UPIN _____

ONGOING CLINICAL MEASURES

		INITIAL MEASUREMENT		SUBSEQUENT MEASUREMENTS					
		Date *mm/dd/yy*	Results	Date *mm/dd/yy*	Results	Date *mm/dd/yy*	Results	Date *mm/dd/yy*	Results
LABORATORY									
Hemoglobin Alc	*At Least Annual*								
FASTING LIPID PROFILE									
Total Cholesterol	*Annual*								
HDL Cholesterol	*Annual*								
LDL Cholesterol	*Annual*								
Fasting Triglycerides	*Annual*								
Urinalysis for Protein	*Annual*		Pos Neg		Pos Neg		Pos Neg		Pos Neg
Quantitative/Semi-Quantitative Urine Protein*			Pos Neg		Pos Neg		Pos Neg		Pos Neg
Microalbumin**									
Creatinine	*Annual*								
MONITORING		**Date**	**Results**	**Date**	**Results**	**Date**	**Results**	**Date**	**Results**
Diabetic Foot Exam	*Annual*								
Dilated Eye Exam	*Annual*								
Blood Pressure	*Each Visit*								
Weight	*Each Visit*								
Review Home Blood Glucose Monitoring	*Each Visit*		Yes No		Yes No		Yes No		Yes No
PREVENTIVE CARE		**Date**	**Results**	**Date**	**Results**	**Date**	**Results**	**Date**	**Results**
Influenza Vaccination	*Annual*								
Pneumococcal Vaccination									
Tobacco Counseling	*PRN*		Nonsmoker Yes No		Nonsmoker Yes No		Nonsmoker Yes No		Nonsmoker Yes No
Diabetes Education	*Each Visit*		Yes No		Yes No		Yes No		Yes No
Dietary Instruction	*Each Visit*		Yes No		Yes No		Yes No		Yes No

Frequency recommendations are for stable diabetics based on ADA guidelines. More frequent monitoring is required for unstable diabetics.

*May be indicated in patients with proteinuria to assess the degree of nephropathy.

**May be indicated in patients with frank proteinuria to assess need for a preventive treatment.

3/99

IOWA FOUNDATION FOR MEDICAL CARE
THE SUNDERBRUCH CORPORATION-NEBRASKA
ILLINOIS FOUNDATION FOR QUALITY HEALTH CARE

Clinical Measure*	Synonyms	Exclusions
Hemoglobin A1c (___%)	Hemoglobin A1; hemoglobin A1c; Hgb A1c; glyco-Hb; GHb; Hb A1c; glycated Hgb; glycohemoglobin; glycohemoglobin A1C	Hgb; Hemoglobin; Hb; Hg without reference to "glycated" or "glycosylated" or "A1" or "A1c"; fructosamine test
Fasting lipid profile (mg/dl)	Triglycerides, or LDL, or HDL, or total cholesterol	None
Urinalysis	Routine urinalysis, routine U/A, Protein +, 1+, 2+	Urine for glucose, diastix, ketodiastix
Quantitative/ Semi-Quantitative urine protein (g/l or g per 24 hrs)	Urine albumin/creatinine ratio, 24 hour urine for protein, 2 hour urine or spot urine for protein or albumin overnight urine for protein, random urine for protein	
Microalbumin (mcg/mg cr)	Micral strip, Microbumitest, 2 hour urine or spot urine for microalbumin	
Creatinine (mg/dl)	Creatinine, serum creatinine, creatinine clearance test	None
Diabetic foot exam (normal/abnormal)	May include use of a flow sheet; mention of visual, sensory, or vascular inspection; patient teaching about foot care, e.g., feet OK or feet negative • **Visual exam**: may refer to foot lesions, ulcers, deformities, clubbing, cyanosis, edema; toe nail clipping; diabetic foot care (DFC). • **Sensory exam**: may refer to sensation in feet; "intact to touch"; Babinski neuro checks; pin prick; impaired vibration sensation; testing with monofilament. • **Vascular exam**: may refer to circulation in feet; temperature; pulses; dorsalis pedis; DP; pedal pulse; ankle/arm ratio.	Documentation of lower extremities without mention of feet: "extremities – no edema"; Doppler flow exams; range of motion (ROM) exams; patient self-report of condition of feet
Dilated eye exam (normal/abnormal)	Dilated = dil, dl, Dl Information must **specifically indicate** that this was a dilated exam.	Any eye exam that simply states the eyes were WNL (within normal limits); PCP note that the fundi were normal without specifically stating the eyes were dilated
Blood pressure (mmHg)	BP; B/P; vital signs; systolic/diastolic	Patient self-report; report of hospital record measurements; use of term "vital signs within normal limits" or "vital signs normal"
Weight (kg)	Patient's weight measured at the time of the office visit	Patient self-report; report of hospital record measurements
Home blood glucose monitoring	Home blood glucose records, self-monitoring of blood glucose, (SMBG), self blood glucose monitoring (SBGM), home blood glucose monitoring (HBGM), blood glucose meter download data	Laboratory blood glucose; capillary blood sugars & AccuChek **unless stated** it is performed at home or by patient
Influenza vaccination	This list is **not** all inclusive: Influenza vaccination; flu shot; influenza immunization; Flu-Immune; Fluogen; Flushield; Flu Shield; Fluzone; Trivalent, Fluvirin	Pnuemococcal vaccine
Pneumococcal vaccination	Pneumovax; pneumococcal pneumonia vaccination; PPV	Influenza vaccine
Tobacco counseling	Smoking cessation counseling; use or reference to use of the following products **for smoking cessation**: Clonidine hydrochloride, Habitrol, Nicoderm, Nicorette, Nicorette Ds, Nicotine, Nicotine Polacrilex, Nicotrol, Prostep, Nicotine patch, nicotine transdermal system	None
Diabetes education	Education by diabetes educator; instruction by physician or nursing staff regarding risk factors, disease processes and preventive health measures	None
Dietary instruction	Education by a dietitian about a diabetic or weight loss diet; instruction by the physicians or nursing staff regarding how to regulate blood sugars with diet	None

*Please include the units (e.g. mg, mcg, dl) you are using to report data **if different** than the units specified above. 6/98