

DIABETES MANAGEMENT PLAN



GENERAL PRACTITIONER

Name and Address: _____ Date: ___/___/___

PATIENT DETAILS

Surname: _____ First Name: _____

Address: _____ Postcode: _____

DOB: / / Sex: M F Aboriginal/Torres Strait Islander: Yes No

HISTORY - Type 1 Type 2 Year of Diagnosis: _____

MANAGEMENT

Diet Only Insulin Metformin Sulphonylurea Other _____

Taking Cortisone: Yes No

Hospitalisations due to diabetes in last 12 months: Yes No

1. BLOOD GLUCOSE CONTROL Current HbA1c: _____ Date: _____

HbA1c readings in last 12 months:

Date	HbA1c	Date	HbA1c

Goal: HbA1c ≤ 7%

Significant hypos' (in last 3 months) Yes No

2. EYES Visual Acuity (corrected) R) _____ L) _____

Visually Impaired (<6/9 with pinhole testing): Yes No Blindness (<6/60) due to Diabetes: Yes No

Cataract: Yes No Cataract Extraction: Yes No

Diabetic Retinopathy: Yes No Laser Treatment: Yes No

Date of last Ophthalmologist/Optomtrist review: / / **Goal: Every 1-2 years.**

3. WEIGHT Weight: _____ kg Height: _____ cm BMI: _____ kg/m² Waist _____ cm

Weight within last 12 months:

Date	Weight	Date	Weight

**Goal: BMI = <25 kg/m²
Waist = ≤94cm Males
Waist = ≤80cm Females**

4. BLOOD PRESSURE Current BP _____/_____ Stroke within the last 12 months? Yes No

Known Hypertensive: Yes No Controlled: Yes No

Ace Inhibitor or Angiotensin II Receptor Antagonist: Yes No Other medication: Yes No

BP Measurements within the last 12 months:

Date	BP	Date	BP

**Goal : <130/80mmHg
<125/75 if proteinuria of >1g/day**

5. FEET

High risk foot :

Yes to one criteria = high risk foot

Past history of ulceration	Yes <input type="checkbox"/> No <input type="checkbox"/>
Neuropathy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Peripheral Vascular disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Deformity eg. Charcots	Yes <input type="checkbox"/> No <input type="checkbox"/>
Amputation due to diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Active foot problem (active ulcer, corn, calluses, nail problems)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Admitted to hospital in last 12 months due to foot problems.	Yes <input type="checkbox"/> No <input type="checkbox"/>

Foot examinations in the last 12 months

Date

**Goal: Identify and control
If high risk, review every
3 to 6 months**

6. LIPIDS

Current: Chol____mmol/L Trig____mmol/L HDL____mmol/L LDL____mmol/l Collection date.../.../...
 Lipid Lowering treatment: Yes No Acute Myocardial Infarction: >1 yr ago Yes No < 1 yr ago Yes No
 Angina: Yes No CABG/Angioplasty: Yes No
 Lipid Measurements within the past 12 months:

Date	Cholesterol	Triglycerides	HDL	LDL
Goal:	<4.0 mmol/l	<2.0 mmol/l	>1.0 mmol/l	<2.5 mmol/l

7. KIDNEYS

Date of last assessment: / / Albumin Creatinine Ratio: _____

Referral to renal physician in last 12 months: Yes No Needing dialysis/end stage renal failure : Yes No

Recommended: Albumin: Creatinine Ratio – first morning spot test.

Female Normal < 3.5 Microalbuminuria 3.6 – 30 Macroalbuminuria >30
Male Normal < 2.5 Microalbuminuria 2.6 – 30 Macroalbuminuria >30

If ACR normal test annually

If microalbuminuria repeat ACR 2x over 6 weeks confirmed diagnosis if 2 out of 3 positive.

If macroalbuminuria do a 24hr urine protein.

8. ASPIRIN

Taking aspirin? Yes No **Goal:** consider aspirin for all diabetics >50 years of age

9 PHYSICAL ACTIVITY

Yes No

Goal: at least 30 mins walking (or equivalent) 5 days or more/week

ALCOHOL CONSUMPTION

Number of standard drinks /day _____

Goal: ≤2 standard drinks (20g)/day men
 ≤1 standard drink (10g)/day women

SMOKING

Never Past Present

Goal : Zero consumption

Patient education provided on Physical Activity Alcohol Smoking

10. COMPLICATION SUMMARY

COMORBIDITIES

<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Foot problems	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Cerebrovascular disease	<input type="checkbox"/> Other (List below)	<input type="checkbox"/> Dyslipidaemia
<input type="checkbox"/> Microalbuminuria	<input type="checkbox"/> Peripheral Vascular disease		<input type="checkbox"/> Obesity
<input type="checkbox"/> Impotence	<input type="checkbox"/> Peripheral Neuropathy		
<input type="checkbox"/> Diabetic Nephropathy	<input type="checkbox"/> Diabetic Maculopathy	<input type="checkbox"/> Psychosocial – eg. Transport, alcohol, Immunisation status etc	

11. REFERRALS AT THIS VISIT

Diabetic Educator Podiatrist Physician Dietitian

Ophthalmologist/Optomtrist Pharmacist (HMR item 900)

Other _____

MANAGEMENT PLAN	Provider	Review

Recommended: GP sends copy of GP Management Plan to nominated referees, patient, and Division database.

PATIENT'S AGREEMENT

I have agreed/my carer has agreed to this GP Management plan and I understand the recommendations.

Signed by Patient/Carer/ or verbal: _____ Date: ___/___/___

Signed by GP: _____ Date: ___/___/___

A review date has been set: Review Date: ___/___/___

**Please send a copy to Diabetes Program Manager, New England Division of General Practice
 Fax 026771 1170 or mail to PO Box 1321 Armidale 2350.**