



<b>Name:</b>
<b>MR#:</b>
<b>DOB:</b>

## Goodman Diabetes Service Outpatient Flow Sheet

Check if done or record result	Date						
<b>Diabetes Control</b>							
Review Blood Sugar Log							
Hypoglycemia/DKA Inquiry							
<b>Complications Monitoring</b>							
Dilated Eye Exam (yearly)							
Foot Exam (q 3 months)							
Check if High Risk <input type="checkbox"/>							
Sensory							
Vascular							
<b>Education Issues</b>							
Diabetes Education Referral (yearly)							
Nutrition Counselling Referral (yearly)							
Smoking Counseling							
Pre-Pregnancy Counseling							
Driving Counseling							
<b>Labs</b>							
Glucose							
Hemoglobin A <sub>1c</sub> (q 3-6 months)							
Hemoglobin/Hematocrit							
BUN/Creatinine (yearly)							
U/A, Microalbumin (yearly)							
Total Cholesterol (yearly)							
Triglycerides (yearly)							
HDL (yearly)							
LDL (yearly)							
ALT/AST							
FT <sub>4</sub> /TSH (yearly if Type 1)							
<b>Therapeutic Interventions</b>							
Vaccinations							
ASA (if indicated)							