

Michigan Quality Improvement Consortium

Diabetes Mellitus Patient Checklist

Patient Name: _____ ID or SS# _____ Sex: M F

DOB: _____

Date of Visit or Date of Result	Date	Result	Date	Result	Date	Result	Date	Result
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Periodic Assessment (At least twice annually)

Tobacco use status								
BP: # [adult goal: 130/80]								
Weight [Specify Lbs. or Kg]								
Height [Specify Inches or Cm]								
BMI								
Foot Exam								
Behavioral Health Assessment								

Results of Lab Tests and Other Studies

HbA1C: #								
LDL: # [goal:<100mg/dl]								
HDL: #								
Triglycerides: #								
Urine protein: #								
Urine microalbumin if UA<1+protein: #								
Dilated Eye Exam [date performed]								

Education, counseling and risk factor modification (Guided Self Management)

Nutrition								
Exercise								
Foot Care								
Cardiovascular risk reduction: Smoking, Blood Pressure, Weight, Lipids								
Glycemic control								
Smoking cessation intervention								
Pre-conception counseling								

Medical Recommendations (At each visit until therapeutic goals are achieved)

ACE inhibitors prescribed for hypertension or albuminuria>30mg/24hr or albumin:creatinine ratio >30mg/g								
Management of cardiovascular risk factors								
Immunizations up-to-date [Td, influenza, pneumonia]								

Additional comments: _____

KEY
 # = Actual Value or P = Service Done/Performed N/A = Not applicable/indicated