

# FLOW SHEET

## DIABETES CENTRE (DC)

Complete on each visit. Check box or record information as appropriate.

Unit No.

Name

Address

Sex

D.O.B.

HC No.

Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (W)

Date of diagnosis: \_\_\_\_\_ d \_\_\_\_\_ m \_\_\_\_\_ y

Type of diabetes:  Type 1  Type 2  IGT  IFG  IGT & IFG Physician: \_\_\_\_\_

Acceptable wt. range (BMI 20-25): \_\_\_\_\_

Ht: \_\_\_\_\_ Htm<sup>2</sup>: \_\_\_\_\_ Goal Wt: \_\_\_\_\_ WC: \_\_\_\_\_

										BLOOD GLUCOSE (d)				LAB DATA						
DATE d/m/y	LOPD (a)	N √	D √	O √	Kg/lbs (Circle)	BP (b)	Med (c)	FT-A	Fasting	2 hr	Q A (e)	A1C	TC / HDL	Ratio TC:HDL	LDL	TG	Med (f)	Creat	CrCl	
							Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>	H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> FC <input type="checkbox"/>	/				/				Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>			
							Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>	H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> FC <input type="checkbox"/>	/				/				Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>			
							Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>	H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> FC <input type="checkbox"/>	/				/				Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>			
							Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>	H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> FC <input type="checkbox"/>	/				/				Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>			
							Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>	H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> FC <input type="checkbox"/>	/				/				Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>			
							Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>	H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> FC <input type="checkbox"/>	/				/				Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>			
							Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>	H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> FC <input type="checkbox"/>	/				/				Y <input type="checkbox"/> N <input type="checkbox"/> ▲ <input type="checkbox"/>			

- (a) Seen at the lab only. Not a DC visit.
- (b) Record weight change, BMI, or waist circumference, if applicable.
- (c) BP med. Check Yes (Y), No (N), or change from previous visit(s). See Med. Sheet.
- (d) Record capillary on top; lab on bottom.
- (e) Local use.
- (f) Lipid med. Check Yes (Y), No (N), or change from previous visit(s). See Med. Sheet.
- (g) Record proteinuria on top; microalbuminuria (ACR) on bottom.
- (h) Check if changed from previous visit.

Allergies:  Y  N

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

		<b>TREATMENT</b>					
TSH	Prot/ Micro  (g)	INSULIN/OAA (Type, Dosage, Time, Frequency)  (h)	Nutrition Therapy*		Exercise**		(e)
			(h)	Ad	Circle	Type	
	/	TDD = ____; ____ u/Kg      ▲ □	▲ □	1 2 3 4	1 2 3 4 5		
	/	TDD = ____; ____ u/Kg      ▲ □	▲ □	1 2 3 4	1 2 3 4 5		
	/	TDD = ____; ____ u/Kg      ▲ □	▲ □	1 2 3 4	1 2 3 4 5		
	/	TDD = ____; ____ u/Kg      ▲ □	▲ □	1 2 3 4	1 2 3 4 5		
	/	TDD = ____; ____ u/Kg      ▲ □	▲ □	1 2 3 4	1 2 3 4 5		
	/	TDD = ____; ____ u/Kg      ▲ □	▲ □	1 2 3 4	1 2 3 4 5		
	/	TDD = ____; ____ u/Kg      ▲ □	▲ □	1 2 3 4	1 2 3 4 5		

**\*NUTRITION THERAPY** (indicate type of meal plan provided; e.g., 1600 cals, CHO counting, ↓ Na, etc.) In the adjacent column, indicate adherence (Ad) to recommendation by circling appropriate # based on the categories noted below.

1. Follows as recommended.
2. Follows ≥ 4 days/week.
3. Unable/unwilling to follow.
4. Revised.

**\*\*EXERCISE** (circle appropriate # based on categories below and write type of exercise in the adjacent column):

1. Consistent moderate exercise (≥ 30 min/day, ≥ 5 times/wk).
2. Regular but less than recommended.
3. Irregular and/or extreme variation in intensity.
4. Able but no attempt to exercise.
5. Unable due to medical conditions.

## SELF-CARE PRACTICES

SMBG					K	Hypo	HEALTH CARE BEHAVIOURS								
	Freq	Use	A T	Comments (record recommendation)		Freq/ Appro. Tx	ID	Sm	Annual Flu Shot	Eye	Dental	P (v)	R (v)	Initials	(e)
	Circle (i)	Circle (j)										(Last date)			
M <input type="checkbox"/>	1 2 3 4	1 2 3 4					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Q <input type="checkbox"/>							
M <input type="checkbox"/>	1 2 3 4	1 2 3 4					▲ <input type="checkbox"/>	▲ <input type="checkbox"/>							
M <input type="checkbox"/>	1 2 3 4	1 2 3 4					▲ <input type="checkbox"/>	▲ <input type="checkbox"/>							
M <input type="checkbox"/>	1 2 3 4	1 2 3 4					▲ <input type="checkbox"/>	▲ <input type="checkbox"/>							
M <input type="checkbox"/>	1 2 3 4	1 2 3 4					▲ <input type="checkbox"/>	▲ <input type="checkbox"/>							
M <input type="checkbox"/>	1 2 3 4	1 2 3 4					▲ <input type="checkbox"/>	▲ <input type="checkbox"/>							
M <input type="checkbox"/>	1 2 3 4	1 2 3 4					▲ <input type="checkbox"/>	▲ <input type="checkbox"/>							

**(i) Frequency:**

- 1) Regular; as recommended.
- 2) Regular but less than recommended.
- 3) Only when feeling poorly.
- 4) Does not test.

**(j) Use:**

- 1) Uses results to modify treatment (diet, exercise, meds).
- 2) Understands results; does not adjust treatment.
- 3) Incorrect interpretation; inappropriate modification.
- 4) Does not use test results.

## FLOW SHEET KEY

<b>WC</b>	Waist circumference
<b>LOPD</b>	Lab Outpatients only. No Diabetes Centre (DC) visit.
<b>N ✓</b>	Seen by nurse.
<b>D ✓</b>	Seen by dietitian.
<b>O ✓</b>	Seen by other discipline; e.g., MD, Social Worker, etc.
<b>BP</b>	Blood pressure
<b>Med</b>	Medication
<b>FT-A</b>	Foot Assessment - Indicate Risk (H-high, assess q 3-4 months; M-moderate, assess q 6 months; L-low, assess annually); or FC-foot clinic assessment outside DC (indicate date).

### **BLOOD GLUCOSE & LAB DATA**

<b>QA</b>	Check (✓) if lab to meter comparison completed.
<b>A1C</b>	Glycated Hemoglobin
<b>TC:HDL</b>	Ratio total cholesterol:High Density Lipoprotein-Cholesterol (TC divided by HDL-C)
<b>LDL</b>	Low Density Lipoprotein
<b>TG</b>	Triglycerides
<b>Creat</b>	Creatinine
<b>CrCl</b>	Creatinine clearance <u>estimate</u> as calculated by the Cockcroft-Gault Formula*
<b>TSH</b>	Thyroid function
<b>Prot/Micro</b>	Proteinuria/Microalbuminuria (ACR)
<b>OAA</b>	Oral Antihyperglycemic Agent

### **TREATMENT**

<b>TDD</b>	Total daily dose (insulin)
<b>u/Kg</b>	Units per kilogram (TDD divided by weight in kg)

### **SELF CARE PRACTICES**

<b>M</b>	Check (✓) if using meter to test blood glucose.
<b>AT</b>	Check (✓) if appropriate technique.
<b>K</b>	Check (✓) if appropriate ketone testing; note n/a if not applicable.
<b>Hypo</b>	Hypoglycemia episodes (On top, indicate freq - times per week/On bottom, check (✓) if appropriate treatment).
<b>ID</b>	Diabetes identification. Check Yes (Y) or No (N) if wearing ID. Check ▲ if subsequent changes; note change.
<b>SM</b>	Smokes - Check Yes (Y), No (N), or Quit (Q). Check (✓) if subsequent changes; note change.
<b>P</b>	Check (✓) to see progress notes.
<b>R</b>	Check (✓) to indicate referral made elsewhere by DC staff - note in progress notes.
<b>Initials</b>	Health professionals' initials (room for 2).

\*Calculation of creatinine clearance in adults using the Cockcroft-Gault Formula:

$$\frac{\text{Creatinine clearance (mL/min)} = (140 - \text{age in years}) \times \text{actual weight (kg)}}{\text{serum creatinine } (\mu\text{mol/L})} \quad \text{Multiply the result by 1.2 for men}$$

Print Name	Signature	Initials