

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Circular No. 40-8
Change 2

21 April 2004

Expires 1 October 2005
Medical Services
DIABETES OUTPATIENT FORMS

MEDCOM Circular 40-8, 1 October 2003, is changed as follows:

1. **HISTORY.** This publication was originally printed on 1 October 2003. This printing publishes Change 2.
2. Material which has been added or modified is indicated by an asterisk.
3. Pages 6 and 7, Appendix A. Remove old pages of MEDCOM Form 705-R (Diabetes Visit) dated Mar 04 and insert new pages dated Apr 04.

Page 8, Appendix A. Remove old page of MEDCOM Form 706-R (Diabetes Flow Sheet) dated Mar 04 and insert new page dated Apr 04.

Pages 9 and 10, Appendix A. Remove old pages of MEDCOM Form 724-R (Diabetes Action Plan) dated Mar 04 and insert new pages dated Apr 04.
4. File this change in front of the publication for reference purposes.

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS AND TREATMENT (Cont)

CAGE: Cut down Annoyed Guilty Eye opener

Medication list reviewed? Yes No

PART B - PHYSICAL EXAM (OBJECTIVE)

PHYSICAL EXAM (*Record significant findings below*)

HEENT: _____

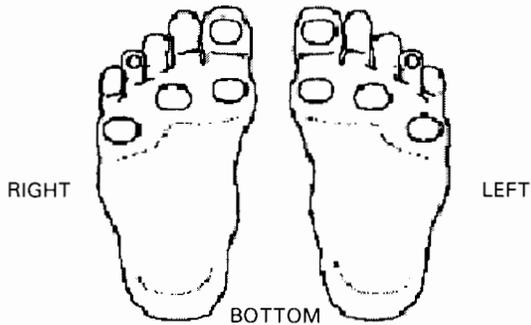
NECK: _____

CV: _____

LUNGS: _____

ABD: _____

EXTREMITIES: _____



FOOT EXAM:	NOT ASSESSED = NA		
A. PEDAL PULSES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA
B. NAILS TOO THICK OR LONG	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA
C. FOOT ABNORMAL SHAPE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA
D. VIBRATORY SENSE INTACT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA
E. EDEMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NA

DRAW/LABEL FINDINGS

C = Callous, U = Ulcer, M = Maceration, R = Redness, S = Swelling

MONOFILAMENT EXAM (Draw in circle):

+ = Positive sensation - = Negative sensation

OTHER: _____

PART C - DIAGNOSIS (ASSESSMENT)

- | | | | |
|---------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> TYPE 1 DM | <input type="checkbox"/> TYPE 2 DM | <input type="checkbox"/> ADEQUATE CONTROL - NO CHANGE IN TREATMENT | <input type="checkbox"/> INADEQUATE CONTROL WITH: |
| <input type="checkbox"/> DYSLIPIDEMIA | <input type="checkbox"/> NEUROPATHY | <input type="checkbox"/> CORONARY ARTERY DISEASE | |
| <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> RETINOPATHY | <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE | |
| <input type="checkbox"/> NEPHROPATHY | <input type="checkbox"/> OBESITY | <input type="checkbox"/> PSYCHOSOCIAL | |
| <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> OTHER: _____ | |

PART D - TREATMENT PLAN

REMARKS: _____

ASA 325 mg ANNUAL FLU VACCINE PNEUMONIA VACCINE ACE INHIBITOR (*Name & Dose*): _____

LABS: A1C LIPIDS MICRO A/CR RATIO TSH CHEM 7 OTHER: _____

DIABETIC ACTION PLAN REVIEWED AND GIVEN TO PATIENT

PART E - REFERRALS

- | | | |
|---|--|--|
| <input type="checkbox"/> DM PATIENT EDUCATION | <input type="checkbox"/> NUTRITION THERAPY | <input type="checkbox"/> PHARMACY |
| <input type="checkbox"/> CASE MANAGEMENT | <input type="checkbox"/> OPHTHALMOLOGY/OPTOMETRY | <input type="checkbox"/> BEHAVIORAL HEALTH |
| <input type="checkbox"/> ENDOCRINOLOGY | <input type="checkbox"/> PODIATRY | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> NEPHROLOGY | <input type="checkbox"/> TOBACCO CESSATION PROGRAM | <input type="checkbox"/> OTHER: _____ |

PART F - FOLLOW-UP APPOINTMENT

1 MONTH 3 MONTHS 6 MONTHS 9 MONTHS OTHER: _____

(Provider's Name)

(Provider's Signature)

MEDICAL RECORD - DIABETES FLOW SHEET

For use of this form see MEDCOM Circular 40-8

1. PRIMARY PROVIDER: _____

2. DIAGNOSIS: TYPE 1 DM TYPE 2 DM DATE OF ONSET: _____

WITH: DYSLIPIDEMIA _____ HTN _____ CAD _____ PVD _____

NEUROPATHY _____ RETINOPATHY _____ NEPHROPATHY _____

PSYCHOSOCIAL _____ OBESITY _____ OTHER _____

3. DATE OF INITIAL DIABETIC EDUCATION: _____

DATE OF VISIT (Month & Year):

4. MONITORED ITEM	PATIENT GOAL	TEST RESULTS							
a. BMI									
b. BP									
c. A1C									
d. LDL									
e. Nephropathy Screen									
f. Dilated Eye Exam									
g. Foot Exam									
h. Tobacco Use									
i. Education Update									
j.									

5. REFERRALS

a. DIABETES EDUCATION									
b. CASE MANAGEMENT									
c. ENDOCRINOLOGY									
d. NEPHROLOGY									
e. NUTRITION THERAPY									
f. OPHTHALMOLOGY/OPTOMETRY									
g. PODIATRY									
h. TOBACCO CESSATION									
i.									

6. PCM CONSIDERATIONS

a. ACE INHIBITORS/ARBs									
b. ASA EVERY DAY									
c. ANNUAL FLU VACCINE									
d. PNEUMONIA VACCINE									

PROVIDER INITIALS:

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

COMMENTS:

DIABETES ACTION PLAN

For use of this form see MEDCOM Circular 40-8

SECTION I - MY DIABETES SELF-MANAGEMENT GOALS

1. SMALL STEPS FOR CHANGE - SELECT AND INITIAL 3 GOALS FROM THE LIST BELOW

(INITIALS) I WILL:

- Monitor my blood sugar _____ times per day, _____ times per week.
- Record my blood sugar in a record book.
- Bring my blood glucose meter to every visit.
- Eat meals and snacks at designated times.
- Use carbohydrate counting to plan my meals.
- Read labels for carbohydrate and fat content.
- Control my portion sizes.
- Build more activity into my day *(by walking, parking further away, taking the stairs):*

- _____
- Enroll in a smoking cessation program.
- Monitor my blood pressure _____ times per _____
- Wash, dry, and examine my feet daily.

2. MEDICATION LIST

I will become familiar with and take the following medications as directed by my health care provider:

3. MY PERSONAL BEST

GOAL FOR NEXT VISIT(S)

DIABETES	MONITORS FOR	ACCEPTABLE RANGE	MY RANGE	Date:	Date:
BMI	Body weight				
Blood pressure	Work of the heart				
A1c	Average 3 month blood sugar				
LDL (lipid)	Heart disease				
Urine Protein	Kidney disease				

SECTION II - MY DIABETES SELF-MANAGEMENT FOLLOW-UP PLAN

I WILL HAVE AN:	DATE	DATE	DATE	DATE
Annual eye exam				
Annual foot assessment				
Annual flu vaccine				
Pneumonia vaccine				

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

(Date Signed)

(Patient's Signature)

(Provider's Signature)

DIABETES SELF MANAGEMENT ACTION PLAN

1. HYPERGLYCEMIA - If I recognize signs/symptoms of hyperglycemia:

- Fatigue
- Excessive thirst
- Frequent urination
- Blurred vision

I will:

- Drink plenty of non-caloric fluids
- Check my blood sugar and ketones
- Adjust my meal plan and activity level
- I will call my primary care provider if my blood sugar is greater than _____ (default value is 250) three times in a row within _____ hours

And I will consider the cause:

- Forgetting to take diabetes medication
 - Overeating
 - Infection/Illness
 - Stress
 - Inactivity
-

2. HYPOGLYCEMIA - If I recognize signs/symptoms of hypoglycemia:

- Weakness
- Rapid heart beat
- Light-headedness or confusion
- Shakiness
- Sweating

I will:

- Eat a snack containing fast-acting carbohydrates (*e.g., juice, cola, skim milk, crackers*)
- Re-check blood sugar in 15 minutes; if less than _____, eat an additional fast-acting carbohydrate
- Eat a meal or snack within 30 minutes

And I will consider the cause:

- Delaying meals
 - Not eating enough food
 - Too much diabetes medication
 - Too much exercise
-

3. SICK DAY RULE - When I am sick:

I will:

- Continue to take my diabetes medication
- Monitor my blood sugar every _____ hours and if greater than _____ test for ketones
- Eat the usual amount of meals and snacks divided into smaller proportions
- Drink fluids frequently (*8 ounces per hour while awake*)

And I will seek medical assistance if I have:

- Blood sugar greater than _____ or double the range set by my health care provider
 - Blood sugar less than _____ that does not improve after eating a meal or snack
 - Fever of 101 degrees or higher
 - Nausea and vomiting, especially if no food or fluid intake for more than 5 hours
 - Symptoms of shakiness, lightheadedness, sweating, rapid heart rate that does not improve after eating a meal or snack
 - Any problems with my feet (*burns, blisters, swelling, bruising or discoloration, bleeding, or oozing of fluid*)
-

(Patient's Signature)

(Date Signed)

(Provider's Signature)

The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6026.

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