

Diabetic Assessment Form

Community Paramedic Line (208)287-2998

Pt Name:	Pt. ID #:	Date: / /
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Pt Knowledge

1. Does the pt understand their disease process? YES NO 2. Did the pt understand their discharge orders? YES NO

Type

Type 1	New onset	Y	N	Metabolic Syndrome	Type 1 / pregnant	Gestational
Type 2	New onset	Y	N	Impaired glucose tolerance	Type 2 / pregnant	Pre diabetes

Complications / Co-morbidities

Hypertension	Mental Disorder	Obesity	Stroke	Celiac disease
Neuropathy	Dyslipidemia	PVD	Renal disease	Gastroparesis
CAD	Retinopathy	Transplant (type):		

Blood Glucose Levels

Daily BG Checks? **Yes** **No** Normal BG range: / mmhg. Current BG reading: mmhg

Assessment

Newly diagnosed with diabetes	Yes	No	N/A
Change from diet to oral medications	Yes	No	N/A
Change from oral to insulin	Yes	No	N/A
2 A1c's >than 8.5 (3 or more months apart)	Yes	No	N/A
Severe Hypo/Hyperglycemia in the past year with ER of hospital visit	Yes	No	N/A
Podiatry Care	Yes	No	N/A
Ophthalmology Care	Yes	No	N/A

Vital Signs

Time	BP	HR	RR	SpO2	Weight	BG	Temp	GCS

ADL

Function	Independent	Needs Help	Dependent	Does not do
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking				
Climbing stairs				
Eating				
Shopping				
Cooking				
Managing medications				
Using the Phone				
Housework				
Doing Laundry				
Driving				
Managing Finances				

Lab Results (i-STAT / A1c)

Notes

Referrals

Signature _____ Print _____ ADA# _____