

# Diabetes Provider Visit Form

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
PCP: \_\_\_\_\_ Date: \_\_\_\_\_

S: Patient Concerns/Summary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ROS: \_\_\_\_\_  
Depression Screening:  1  2 Question  PHQ-9 Done

CHART:  PMH Reviewed  Soc Hx. Reviewed  FMHx Reviewed

Previous Self Management Goal Kept?  YES  NO  
Recent Average Home BS: AM Fasting = \_\_\_\_\_ PM 2 hr postprandial= \_\_\_\_\_  
Current Medications: 1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_  
5) \_\_\_\_\_ 6) \_\_\_\_\_

Has Patient missed any doses of their medications?  YES  NO  
Comments \_\_\_\_\_

Does Patient SMOKE?  Current  Past  Never  
Open to quitting? (Give Form if ready for change)  YES  NO

O: BP: \_\_\_\_\_ (Goal <130/75) Ht: \_\_\_\_\_ Exam: \_\_\_\_\_  
WT: \_\_\_\_\_ BMI: \_\_\_\_\_ (Patient Goal \_\_\_\_\_)  
Foot Exam Score: R \_\_\_\_\_ L \_\_\_\_\_ Date: \_\_\_\_\_ Other Labs: \_\_\_\_\_  
(complete foot reviewed form)  
PHQ-9 Score: \_\_\_\_\_ Cholesterol: \_\_\_\_\_ Date: \_\_\_\_\_  
Labs: HBA1C \_\_\_\_\_ Date \_\_\_\_\_ Creatinine: \_\_\_\_\_ Date \_\_\_\_\_  
MicroAlb. \_\_\_\_\_ Date \_\_\_\_\_ Triglycerides: \_\_\_\_\_ Date \_\_\_\_\_  
LDL \_\_\_\_\_ Date \_\_\_\_\_ HDL: \_\_\_\_\_ Date \_\_\_\_\_

A: 1) DIABETES MELLITUS II: Control is  Good (<6.6)  Fair (<8.0)  Poor (>8.0)  
a) \_\_\_\_\_  
b) \_\_\_\_\_  
c) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_

P: MEDICATION CHANGES: \_\_\_\_\_

LABS: \_\_\_\_\_

REFERRALS: Nutrition/Diabetes Education  YES  NO  UTD  
Ophthalmology  YES  NO  UTD  
Group Visit  YES  NO  Already Invited  
Other \_\_\_\_\_

IMMUNIZATIONS:  UTD  Pneumovax  Flu  Tetanus  \_\_\_\_\_  
Next Planned Visit (call back card)  YES  NO Month/Year? \_\_\_\_\_  
Smoking Cessation Counseling Offered  YES  NO  N/A  
See Dictated Note:  YES  NO  
Patient Education Information Given  YES  NOT NEEDED

NEW SELF-MANAGEMENT GOAL: \_\_\_\_\_ (L.O.S. score=\_\_\_\_\_)

Provider: \_\_\_\_\_ Preceptor: \_\_\_\_\_

Billing Code: \_\_\_\_\_ Date: \_\_\_\_\_