

Patient Name: _____ Age: ____ Date: _____ PCP _____

BP ____/____ Pulse ____ Height ____ Weight ____ Last A1c (date) _____
Last Flu Vaccine ____ Last Pneumovax ____ Last Cl Cr ____ U.MicroAlb ____ (date) _____

Last eye exam/results _____ **Has current presc. for Glucagon?** Y/ N

Med Sheet Reviewed? Y/ N **Any foot problems?** Y/ N **BG Meter** _____ **Type 1/Type 2**

Meal Coverage Insulin (MDI/ Pump): B _____ L _____ S _____ HS _____

Injectable Basal Insulin(s) _____ Pump Basal rates: _____

Ins./CHO ratio _____ Correction formula _____

Interval Hx:

Physical Exam:

Impression:

- 1). _____
- 2) _____
- 3) _____
- 4) _____

Today's Tests: A1c _____ Chol _____ Trig _____ HDL _____ LDL _____

CMP _____

Plan:

Follow up Plans:

Total Time - _____ **Counseling time** - _____ **Lab On Return:** _____

Copies to: _____ (MD, RN, MSN, FNP,ETC)