

Diabetes Annual Cycle of Care checklist

PATIENT NAME: _____

ACTIVITY	FREQUENCY	DATE COMPLETED	DATE COMPLETED
Measurement of HbA1c	At least once per year	___/___/___	___/___/___
Total Cholesterol, triglycerides and HDL - cholesterol	At least once per year	___/___/___	___/___/___
Test for urinary microalbumin	At least once per year	___/___/___	___/___/___
Measure Blood Pressure	Every 6 months	___/___/___	___/___/___
Measure height, weight and calculate BMI	Every 6 months	___/___/___	___/___/___
Examine Feet	Every 6 months	___/___/___	___/___/___
Comprehensive eye examination	Every 2 years	___/___/___	___/___/___
Review Diet	Yearly	___/___/___	___/___/___
Review Activity	Yearly	___/___/___	___/___/___
Provide self care education	Yearly	___/___/___	___/___/___
Review medication	Yearly	___/___/___	___/___/___
Review smoking status	Yearly	___/___/___	___/___/___