

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

8 January 2001

Expires 15 November 2001

Medical Services

**DIABETIC OUTPATIENT FORMS**

MEDCOM Cir 40-8, 15 November 1999, is changed as follows:

1. **HISTORY.** This publication was originally printed on 15 November 1999. Change 1 was printed on 10 October 2000. This printing publishes Change 2.

2. Page 2. Add subparagraphs 8c(1), (2), and (3) after subparagraph 8b(3) as follows:

c. MEDCOM Form 724-R (Diabetes Action Plan).

(1) Purpose. The form may be used to document diabetes self-management goals in the first clinic visit of a "new" diabetic patient or return visits of patients with diabetes.

(2) Preparation. This form has two sections and a diabetes self-management action plan. Section I, My Diabetes Self-Management Goals, Medication List and My Personal Best, is to be completed by the patient and reviewed by the Primary Care Provider or Diabetes Educator/Case Manager. Section II, My Diabetes Self-Management Follow-Up Plan, is to be completed by the patient and reviewed by the Primary Care Provider or Diabetes Educator/Case Manager. The Diabetes Self-Management Action Plan is to be reviewed and completed by the patient and reviewed by the Primary Care Provider or Diabetes Educator/Case Manager. The patient and provider date and sign the front and back of the form.

(3) Content. Section I includes documentation of Diabetes Self-Management Goals in which the patient selects and initials at least three goals from the list. The Medication List includes a place to record diabetes medications. My Personal Best includes BMI, Blood Pressure, HbA1c, LDL, Urine Protein, Monitors For, Acceptable Range, My Range, and Goal for Next Visit. Section II includes eye exam, foot assessment, annual flu vaccine, pneumonia vaccine, and the dates. Diabetes Self-Management Action Plan includes signs and symptoms, I will do and I will consider sections; the cause of hyperglycemia, hypoglycemia, and sick day rules.

Pages 4 and 5, Appendix A. Remove old pages of MEDCOM Form 705-R (Diabetes Visit) dated September 2000 and insert new pages (Diabetes Visit) dated December 2000.

Page 6, Appendix A. Remove old page of MEDCOM Form 706-R (Diabetes Flow Sheet) dated September 2000 and insert new page (Diabetes Flow Sheet) dated December 2000.

C2, MEDCOM Cir 40-8

Pages 7 and 8, Appendix A. Insert new pages of MEDCOM Form 724-R (Diabetes Action Plan) dated December 2000.

3. File this change in front of publication for reference purposes.

(MCHO-Q)

OFFICIAL:

PATRICK D. SCULLEY  
Major General  
Chief of Staff

THOMAS J. SEMARGE  
Colonel, MS  
Assistant Chief of Staff for  
Information Management

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

COMMENTS/ADDITIONAL HISTORY:

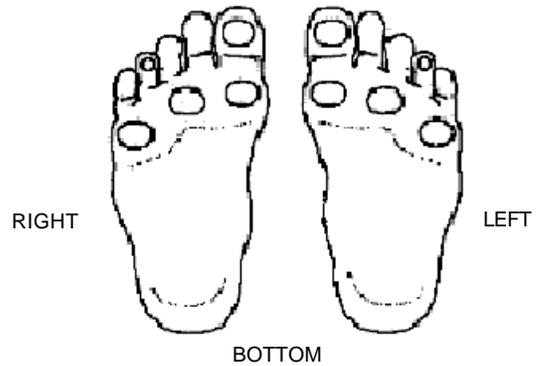
**PART B - PHYSICAL EXAM (OBJECTIVE)**

PHYSICAL EXAM (*Record significant findings below*)

- FOOT EXAM:  NOT ASSESSED
- A. PEDAL PULSES  YES  NO
- B. NAILS TOO THICK OR LONG  YES  NO
- C. FOOT ABNORMAL SHAPE  YES  NO
- D. VIBRATORY SENSE INTACT  YES  NO

DRAW/LABEL FINDINGS

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



Lab results in CHCS  YES  NO

MONOFILAMENT EXAM (Draw in circle):  
 + =Positive sensation    - =Negative sensation

**PART C - DIAGNOSIS (ASSESSMENT)**

TYPE 1 DM     TYPE 2 DM     ADEQUATE CONTROL - NO CHANGE IN TREATMENT     INADEQUATE CONTROL

WITH:

1. DYSLIPIDEMIA  YES  NO
2. HYPERTENSION  YES  NO
3. NEPHROPATHY  YES  NO

WITH:

4. NEUROPATHY  YES  NO
5. RETINOPATHY  YES  NO
6. \_\_\_\_\_  YES  NO

**PART D - TREATMENT PLAN (PLAN)**

RECOMMEND:

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

LABS:  HbA1C     LIPIDS     MICRO A/CR RATIO     TSH     CHEM 7     OTHER: \_\_\_\_\_

DIABETIC ACTION PLAN REVIEWED AND GIVEN TO PATIENT

**PART E - REFERRALS**

- A. DM PATIENT EDUCATION/ CASE MANAGEMENT     D. NUTRITION THERAPY     H. OTHER \_\_\_\_\_
- B. ENDOCRINOLOGY     E. OPHTHALMOLOGY/OPTOMETRY \_\_\_\_\_
- C. NEPHROLOGY     F. PODIATRY \_\_\_\_\_
- G. TOBACCO CESSATION PROGRAM \_\_\_\_\_

**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:     HTN             CAD             PVD             DYSLIPIDEMIA

NEUROPATHY             RETINOPATHY             NEPHROPATHY

PSYCHOSOCIAL             OTHER             OTHER

3. DATE OF INITIAL DIABETIC EDUCATION: \_\_\_\_\_

DATE OF VISIT (Month & Year):

--	--	--	--	--	--	--	--	--	--

4. MONITORED ITEM	DQIP TARGET	PT GOAL	TEST RESULTS							
a. BMI										
b. BP	% < 140/90									
c. HbA1C	% Highest Risk > 9.5									
d. LDL	% < 130									
e. Micro Alb	% Assessed									
f. Serum CR	% Assessed									
g. Dilated Eye Exam	% Assessed									
h. Foot Exam	% Assessed									
i. Education Update										
j.										

**5. REFERRALS**

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

**6. PCM CONSIDERATIONS**

a. ACE INHIBITORS									
b. ASA q DAY									
c. ANNUAL FLU VACCINE									
d. PNEUMONIA VACCINE									

**PROVIDER INITIALS:**

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

## 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				
HbA1c	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)*

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## DIABETES SELF MANAGEMENT ACTION PLAN

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### 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 > \_\_\_\_\_ (*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

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### 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 < \_\_\_\_\_, 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

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### 3. SICK DAY RULE - When I am sick:

#### I will:

- Continue to take my diabetes medication
- Monitor my blood sugar every \_\_\_\_\_ hours and if > \_\_\_\_\_ 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 > \_\_\_\_\_ or double the range set by my health care provider
- Blood sugar < \_\_\_\_\_ 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*)

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(Patient's Signature)

(Date Signed)

(Provider's Signature)