CHW Diabetes Clinical Assessment Log Sheet

Patient Name: _____
OHIP Number: _____
Date: _____
Assessed By: _____ Community: _____

1. Height: _____cm (Do this only if height has never been recorded before)
*Remember: have patient remove shoes, hair ornaments, hats etc.

2. Weight: _____ kg
*Remember: have patient remove shoes, heavy clothing, items in pockets etc.

3. Blood Pressure: BP#1: _____/_____ BP#2: _____/_____ BP#3: _____/_____
HR#1: _____ HR#2: _____ HR#3: _____
*Remember: feel for the big artery in the bend of the elbow before taking the blood pressure.
*Remember: If the blood pressure more than 160/100, have patient rest for 5 minutes and repeat blood pressure 3 times.

Refer to Nurse? ☐ Yes ☐ No
[ONLY if blood pressure more than 160/100 after 3 measurements]

4. Blood Sugar: _____
*Remember: wash your hands (or put on gloves).
*Remember: ask the patient to wash their hands.

Refer to Nurse? ☐ Yes ☐ No
[ONLY if blood sugar LESS than 4.0 *or* MORE than 20.0]

5. Logbook:
Is logbook or readings from glucometer available today? ☐ Yes ☐ No
If yes, then frequency of blood sugar checks in the past two weeks is:
☐ None ☐ 1-2/week ☐ 3-6/week ☐ Every day

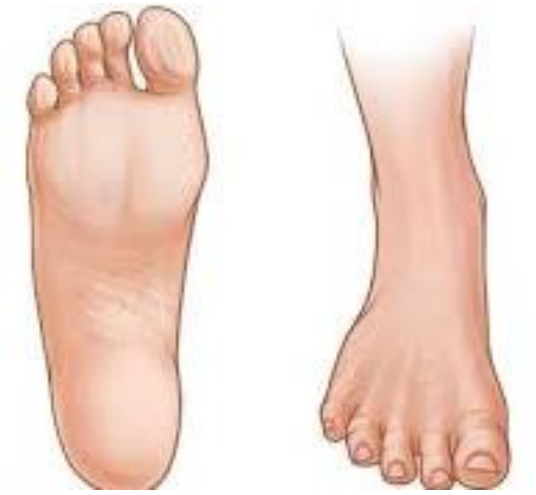
Last 5 pre-meal readings: 1._____ 2. _____ 3._____ 4._____ 5._____
Last 5 post-meal readings: 1._____ 2. _____ 3._____ 4._____ 5._____

Comments:_____
_____
_____

6. Foot Exam:

*Remember: check above and below foot, heels, and *in between* the toes

RIGHT Foot

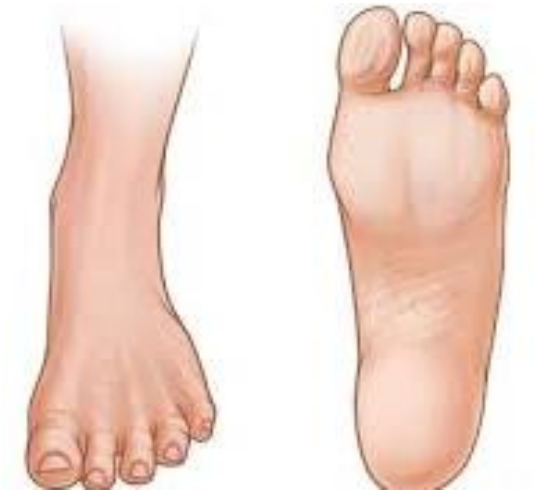


☐ Normal

OR

☐ Cuts ☐ Redness ☐ Ulcers
☐ Numbness or tingling

LEFT Foot



☐ Normal

OR

☐ Cuts ☐ Redness ☐ Ulcers
☐ Numbness or tingling

Comments:_____
_____
_____
_____

Refer to Nurse? ☐ Yes ☐ No
[ONLY if any NEW or WORSENING foot problems: ulcer, cut, redness, numbness and tingling]

7. Medication Review:

a. Is the patient taking his or her medications regularly?

☐ Yes, Always ☐ Yes, Most of the Time

☐ No, Misses Meds Often ☐ No, Not Taking Meds At All

If no, why? _____

_____

_____

If no, is there a specific drug that you are having difficulty taking? _____

_____

b. Do you notice any problems with the patient's blister pack? (patient forgot to take medications, patient taking medications on the wrong day of the week)

☐ Yes ☐ No

If yes, what do you notice? _____

_____

_____

c. Is the patient having any side effects from their medications?

☐ Yes ☐ No

If Yes, which side effect(s)?

☐ Nausea ☐ Vomiting ☐ Gas ☐ Loose Stools ☐ Headache

☐ Dizziness ☐ Muscle Cramps ☐ Low Blood Sugar (less than 4.0)

☐ Other(s):_____

Comments:_____

_____

_____

_____

Refer to Nurse? ☐ Yes ☐ No

[ONLY if the patient is not taking their medications as prescribed]

8. Self-Management Review:

Is patient smoking? □ Yes □ No

What are you currently doing to manage your diabetes besides taking medication(s)?

*Remember: encourage patient to set specific target & date when they will achieve target (e.g. I will walk 3 times a week to the band office for 15 minutes).

Diet:_____
_____
_____
_____

Exercise:_____
_____
_____
_____

Smoking:_____
_____
_____

Drugs and Alcohol:_____
_____
_____
_____

9. Referral Process:

For any reason in Pages 1-4, do you need to refer the client for further care?

☐ Yes ☐ No

If yes, then report it to the nurse on same day as the visit, & enter info below:

Date Discussed with Nurse: _____

Name of Nurse: _____

Date of next client visit? _____

Check if data entered into the Patient Registry ☐