**CHW Diabetes Clinical Assessment Log Sheet**

**\*\*Review CHW Diabetes Clinical Assessment Log Sheet Instruction Guide for complete guidelines for each task and proper documentation.**

|  |  |
| --- | --- |
| Client Name: | Day/Month/Year: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| OHIP Number: | Community:  |
| Assessed By:  |

|  |  |
| --- | --- |
| **1. Height:** \_\_\_\_\_\_\_\_\_\_\_cm  | **2. Weight:** \_\_\_\_\_\_\_\_\_\_ kg |
| Comments: |

|  |
| --- |
| **3. Blood Pressure** |
| BP#1 (Left arm) \_\_\_\_/\_\_\_\_ | BP#2 (Right Arm) \_\_\_\_/\_\_\_\_ | Choose the arm with higher systolic reading (1st number) for the next 2 BPs.  |
| L or R BP #3\_\_\_\_/\_\_\_\_ | L or R BP #4\_\_\_\_/\_\_\_\_ |
| Discard BP 1 & 2Calculate the average of the BP 3 & 4 only by adding and then divide by 2 | Average BP of 3 & 4 = \_\_\_\_/\_\_\_\_ |
| Comments: |  |
| If BP more than 150/90, have client rest for 5 mins, repeat BP 3 times \*\*Same day referral to Nurse? [ONLY if BP average more than 150/90] \*\*Refer to Nurse for Follow up? [Client NOT at target, higher than 130/80, or more than 10 points difference in systolic pressure (1st number) between left and right arms]  | Average: \_\_\_\_/\_\_\_\_Yes NoYes No |

|  |  |
| --- | --- |
| **4. Blood Glucose** | \_\_\_\_\_\_\_ mmol/L |
| Comments: |
| \*\*Refer to Nurse? [ONLY if blood sugar LESS than 4.0 *or* MORE than 25.0] \*\*Refer to Nurse [Blood sugar is high but less than 25.0, AND is has clinical signs and symptoms of hyperglycemia or is unwell] | Yes NoYes No |

|  |
| --- |
| **5. Logbook and Glucose meter** |
| Is the patient keeping a record of their blood sugars (logbook or glucometer)? Recommended blood glucose testing: \_\_\_\_\_x/day \_\_\_\_\_x/weekFrequency of blood glucose measurements  □ No testing □ 1-2x/ week □ 1-2x a day □ 3-6 x/day If yes, then write down, for readings *over the past two weeks*:  Number of readings:\_\_\_\_\_\_ Lowest:\_\_\_\_\_\_ Highest :\_\_\_\_\_\_  | Yes NoAverage Blood Glucose: \_\_\_\_\_\_\_ |
| Problems with testing? (out of supplies, lost glucometer, frequent lows, etc.) Comments: | Yes No |
| Refer to Nurse? [If out of supplies, lost glucose meter, or frequent lows, etc.]  | Yes No |

|  |
| --- |
| **6. Quick Foot Check - Inspection** |
|  RIGHT Foot https://encrypted-tbn1.gstatic.com/images?q=tbn:ANd9GcSL7XFnYpgIdcvjlSxfClPhitl7__eshwA6GCTDMY6dzwJ1g0Sb | □ Normal □ Cuts, blisters, bruises, redness, ulcers/sores, signs of infection, cracks, new numbness, or tingling□Pain or discomfort especially during sleep or rest | https://encrypted-tbn1.gstatic.com/images?q=tbn:ANd9GcSL7XFnYpgIdcvjlSxfClPhitl7__eshwA6GCTDMY6dzwJ1g0SbLEFT Foot  | □ Normal □ Cuts, blisters, bruises, redness, ulcers/sores, signs of infection, cracks, new numbness, or tingling□ Pain or discomfort especially during sleep or rest |
| □ Nails are overgrown or callous build up | □ Nails are overgrown or callous build up |
| Comments: |
| Refer to Nurse? [ONLY if NEW or WORSENING foot problems] Refer to Foot Care? [If nails are overgrown or callous buildup] | Yes NoYes No |

|  |
| --- |
| **7. Medication Review** |
| Ask client if he/she is taking his/her medications regularly. □Yes, Always □Yes, Most of the Time □No, Misses Meds Often □No, Not at All If no, is there a specific drug that the client is having difficulty taking?  Examine the blister pack. Did client miss some doses?  | If no, why? □ Yes □ No |
| Is the client having any side effects from their medications? If Yes, which side effect(s)? □ Nausea □Vomiting □Gas □Loose Stools □Headache □Dizziness □Low Blood Sugar (less than 4.0) □Muscle Cramps  | □ Yes □ NoOther:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Comments: |
| Refer to Nurse? [ONLY if not taking meds, or side effects]  | □ Yes □ No |

|  |
| --- |
| **8. Self-Management Review** |
| Ask Client:  | What kind of things are you currently doing to manage your diabetes?Set specific goals and time targets for diet, exercise, tobacco, drugs, or alcohol use(e.g. Over the next two weeks, I will walk 3 x a week to the band office for 15 minutes). |
| Tobacco Use |  Yes No |
| Diet |  |
| Exercise |  |
| Drugs & Alcohol |  |
| Comments: |

|  |
| --- |
| **9. Referral Process** |
| On pages 1-2, did you need to refer the client for further care?  | Yes No  |
| If yes: Date discussed with nurse: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Name of nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |