**CHW Diabetes Clinical Assessment Log Sheet**

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

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

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

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| **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 & 2  Calculate 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 No  Yes No |

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| **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 No  Yes No |

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| **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/week  Frequency 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 No  Average 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 |

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| **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 No  Yes No |

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| **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 □ No  Other:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Comments: | |
| Refer to Nurse? [ONLY if not taking meds, or side effects] | □ Yes □ No |

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| **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: | |

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |