

## DIABETES ASSESSMENT

**Patient's name** \_\_\_\_\_

**History** (no frequency requirement for PIP payment)

- |                      |  |               |
|----------------------|--|---------------|
| * Smoking            | No/Yes – advised to QUIT               | .../.../..... |
| * Dietary compliance | Satisfactory/Poor – advice given       | .../.../..... |
| * Physical activity  | Satisfactory/Inadequate – advice given | .../.../..... |

**Examination** (6/12)

- |                 |                                |           |          |     |               |
|-----------------|--------------------------------|-----------|----------|-----|---------------|
| * Height .....  | Weight .....                   | BMI ..... | BP ..... | (1) | .../.../..... |
|                 |                                |           |          | (2) | .../.../..... |
| * Feet - Pulses | Palpable / Diminished / Absent |           |          | (1) | .../.../..... |
| - Sensation     | Normal / Peripheral neuropathy |           |          | (2) | .../.../..... |

**Investigations** (12/12)

- |                        |               |
|------------------------|---------------|
| * HbA1C                | .../.../..... |
| * Microalbumin         | .../.../..... |
| * Lipids - cholesterol | .../.../..... |
| - triglycerides        | .../.../..... |
| - HDL                  | .../.../..... |
| - LDL                  | .../.../..... |

**Referrals** (2 yrs)

- |                   |               |
|-------------------|---------------|
| * Ophthalmologist | .../.../..... |
|-------------------|---------------|

**Medication** (no frequency requirement for PIP payment)

- |                     |               |
|---------------------|---------------|
| * Review Medication | .../.../..... |
|---------------------|---------------|

**Patient Education** (no frequency requirement for PIP payment)

- |                     |               |
|---------------------|---------------|
| * Self care         | .../.../..... |
| * Review diet       | .../.../..... |
| * Physical activity | .../.../..... |

**Comments**

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Use special Medicare Item number when the above have been *completed*

Place on **'Diabetes Review & Recall'** – *annually*