



This form is used to record Diabetic Performance Measures for the Quality Improvement and Incentive Program

Physician Name:	CHS ID:	Type 1 diabetes <input type="checkbox"/> Type 2 diabetes <input type="checkbox"/>
Patient Name:	DOB:	Controlled <input type="checkbox"/> Uncontrolled <input type="checkbox"/>
Insurance:	Member ID:	Patient inappropriate <input type="checkbox"/>

Most Recent Ongoing Measurements to be recorded at each patient visit (2006 and Forward)

Hemoglobin A1c: Performed at least two times in 12 month period. ADA Goal: <7					
Most recent performed	_/_/____	_/_/____	_/_/____	_/_/____	_/_/____
Results (%)					

flu vaccine annual, pneumococcal -once

Dental every 6 months-refer to dentist

LDL: Performed at least one time in 12 month period. NCEP Goal: < 100 mg/dl HDL > 40 mg/dl men, HDL>50mg/dl women, triglycerides <150mg/dl

Date Performed	_/_/____	_/_/____	_/_/____
Results			

Microalbumin: Performed at least one time in 12 month period. > 30ug/mg creatinine is abnormal

Date Performed	_/_/____	_/_/____	_/_/____
Results			

Glomerular Filtration Rate (GFR): Performed at least one time in 12 month period.

Date Performed	_/_/____	_/_/____	_/_/____
Results			

Does Patient have Renal Manifestations: Yes , No , If Yes, this patients diagnostic codes include 250.4. Remember to code co-morbidities.

Blood Pressure Management: ADA Goal: < 130/80 mm Hg

Date Performed	_/_/____	_/_/____	_/_/____
Results			

Counseling and risk reduction Tobacco use ,depression screening, sexual functioning, – annual and ongoing preconception, pregnancy, ASA therapy, ACE or ARB ongoing

Self Management patient and clinician jointly set goals, physical activity, nutrition, self monitor glucose, foot screening

Foot Exam Performed: Goal: At least one exam in 12 month period. For high risk patients do every 3-6 months	_/_/____ <input type="checkbox"/> Sensory NML ABNL If ABNL Does this patient have neurological manifestations Yes <input type="checkbox"/>, No <input type="checkbox"/>, If Yes include diagnostic code 250.6. Remember to code co-morbidities. <input type="checkbox"/> Vascular NML ABNL If ABNL Does this patient have peripheral circulatory disorder: Yes <input type="checkbox"/> No <input type="checkbox"/>, If Yes include diagnostic code 250.7. Remember to code co-morbidities <input type="checkbox"/> Inspection NML ABNL	_/_/____ <input type="checkbox"/> Sensory NML ABNL If ABNL Does this patient have neurological manifestations Yes <input type="checkbox"/>, No <input type="checkbox"/>, If Yes include diagnostic code 250.6. Remember to code co-morbidities. <input type="checkbox"/> Vascular NML ABNL If ABNL Does this patient have peripheral circulatory disorder: Yes <input type="checkbox"/> No <input type="checkbox"/>, If Yes include diagnostic code 250.7. Remember to code co-morbidities. <input type="checkbox"/> Inspection NML ABNL	_/_/____ <input type="checkbox"/> Sensory NML ABNL If ABNL Does this patient have neurological manifestations Yes <input type="checkbox"/>, No <input type="checkbox"/>, If Yes include diagnostic code 250.6. Remember to code co-morbidities. <input type="checkbox"/> Vascular NML ABNL If ABNL Does this patient have peripheral circulatory disorder: Yes <input type="checkbox"/> No <input type="checkbox"/>, If Yes include diagnostic code 250.7. Remember to code co-morbidities. <input type="checkbox"/> Inspection NML ABNL
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➤ Indicate results of each test (circle): NML = Normal findings ABNL = Abnormal findings

Dilated Retinal Eye Exam: At least one exam in a 12 month period	_/_/____ (mm/yy) <input type="checkbox"/> Report Received	_/_/____ (mm/yy) <input type="checkbox"/> Report Received	_/_/____ (mm/yy) <input type="checkbox"/> Report Received
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Is Retinopathy present in this patient: Yes No . If Yes include diagnostic code 250.5 for this patient. Remember to code co-morbidities.

- ❖ Please rate patient compliance with treatment plan (circle): Excellent Very Good Good Fair Poor
- ❖ Would this patient benefit from a Disease Management program for Diabetes: Yes No
- ❖ Based upon NYDC guidelines