

# STANDING ORDERS DIABETES MELLITUS – Type II

**St. Peter Family Medicine**  
525 Lilly Road NE \*Olympia, WA 98506  
(360) 493-7230 \* fax (360) 493-4180

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

	Performed?		Action	Result
	Y	N		
<b>PHYSICAL EXAM</b>	<input type="checkbox"/>	<input type="checkbox"/>	Weight and BMI every visit	Wt: _____ lbs    Ht: _____ inches
	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure every visit	BP: _____    BMI: _____
	<input type="checkbox"/>	<input type="checkbox"/>	Foot check every 4 months (on back of form)	Foot Check: _____ / _____ (left)                          (right)
<b>LABORATORY TESTS</b>	<input type="checkbox"/>	<input type="checkbox"/>	HbA1C every 4 months, or _____	
	<input type="checkbox"/>	<input type="checkbox"/>	Fasting Lipid profile every 1 year, or _____	
	<input type="checkbox"/>	<input type="checkbox"/>	Urine Microalbumin/Creatinine ratio every 1 year, or _____	
	<input type="checkbox"/>	<input type="checkbox"/>	Creatinine every 1 year, or _____	
<b>IMMUNIZATIONS</b>	<input type="checkbox"/>	<input type="checkbox"/>	Flu Shot (Influenza) every 1 year	
	<input type="checkbox"/>	<input type="checkbox"/>	Td every 10 years	
	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal Vaccine 1 time dose	
			Revaccinate 1 time if the patient is: ≥ 65 years old and if the 1 <sup>st</sup> dose was given at < 65 years and greater than 5 years ago	
<b>REFERRALS</b>	<input type="checkbox"/>	<input type="checkbox"/>	Ophthalmology dilated exam every 1 year	
	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes education (Boldt Diabetes Center) -offer every 1 year, if poor glycemic control.	
	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes group visit (SPFP) – offer every 4 months.	
<b>SELF MANAGEMENT GOAL SETTING &amp; SUPPORT</b>	<input type="checkbox"/>	<input type="checkbox"/>	Set Self-Management Goal with patient and record on CDEMS form including likelihood of success score (LOS score)	Goal: • What/Where: _____ • How much: _____ • When: _____ • How often: _____ • Score: _____
	<input type="checkbox"/>	<input type="checkbox"/>	Complete MA call back card for 2 to 3 weeks to review and refine self management goal	
	<input type="checkbox"/>	<input type="checkbox"/>	Pedometer <i>Would you like to discover how active you are? Do you see yourself using a pedometer?</i>	
<b>OTHER</b>	<input type="checkbox"/>	<input type="checkbox"/>	Update CDEMS form and enter data	
	<input type="checkbox"/>	<input type="checkbox"/>	Schedule appointment with PCP within 1 week (15 min. EST.)	
	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes education material offered	
	<input type="checkbox"/>	<input type="checkbox"/>	Call back card for planned visit in 4 months	
	<input type="checkbox"/>	<input type="checkbox"/>	Discuss smoking cessation if indicated	

<b>MA/RN Signature</b> _____	<b>Date</b> _____
<b>PCP Signature:</b> _____	<b>Date:</b> _____