

SK CDM-QIP Diabetes + CAD Flow Sheet

Type of Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other Date Diagnosed/Duration of DM: _____		Patient Name: Date of Birth: HSN:			
CAD History and Interventions: <input type="checkbox"/> MI or ACS date _____ <input type="checkbox"/> Angina date _____ <input type="checkbox"/> PCI/Angioplasty + stent date _____ <input type="checkbox"/> PCI only date _____ <input type="checkbox"/> CABG date _____					
Comorbidities: <input type="checkbox"/> Hypertension <input type="checkbox"/> HF <input type="checkbox"/> AF <input type="checkbox"/> CVA <input type="checkbox"/> PAD <input type="checkbox"/> OSA <input type="checkbox"/> CKD stage ____ <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> Other					
		Date:	Date:	Date:	
Subjective					
Glycemic Management	A1c (target ≤ 7% or _____)	<i>Result</i>	<i>Test Date</i>	<i>Result</i>	<i>Test Date</i>
	Glycemic Therapy/Medications				
	Adherence/concerns				
	Review glucose records				
	Hypoglycemic episodes <small>Consider frequency, severity; provide educational resources</small>				
	DM and driving discussed <small>SGI medical reporting form if using insulin</small>				
	Contraception/preconception advice for women				
	Sick day management reviewed <small>Consider SADMANS, other patient handouts</small>				
Cardiac History & Stability	Any CAD/PAD/HF symptoms <small>(angina/MI symptoms, palpitations, exertional dyspnea, change in exercise tolerance, HF symptoms, edema, claudication, nitroglycerin use)</small>				
	Change in functional status or new CV complications				
Psychosocial review	Is patient experiencing low mood/anhedonia/anxiety? <small>(Consider use of PHQ-9, GAD-7, diabetes distress scales)</small> Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked	



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		Date:	Date:	Date:
Lifestyle	Nutrition/Diet review			
	Physical activity <i>(Reduce sedentary time, aerobic plus resistance exercise)</i>			
	Smoking status	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Smoker	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Smoker	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Smoker
	Smoking cessation advice <i>(if required)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CVD Investigations	ECG <i>(Consider if CVD symptoms; q 1-2 years if stable)</i>	<input type="checkbox"/> Ordered today <input type="checkbox"/> Up to date	<input type="checkbox"/> Ordered today <input type="checkbox"/> Up to date	<input type="checkbox"/> Ordered today <input type="checkbox"/> Up to date
	Other – Echo, Angiogram, Nuclear Med Perfusion Scan			
	Lipid profile – LDL, non-HDL <i>(Primary target: LDL < 2.0 mmol/L or >50% reduction with treatment; non-HDL < 2.6 mmol/L)</i>	LDL <i>Result Test Date</i> Non-HDL	LDL <i>Result Test Date</i> Non-HDL	LDL <i>Result Test Date</i> Non-HDL
Nephropathy	Serum creatinine	<i>Result Test Date</i>	<i>Result Test Date</i>	<i>Result Test Date</i>
	eGFR <i>(normal > 60ml/min)</i>	<i>Result Test Date</i>	<i>Result Test Date</i>	<i>Result Test Date</i>
	Nephropathy <i>(Abnormal ACR, eGFR on ≥ 2 tests in 3 months)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retinopathy	Dilated eye exam <i>(type 1 annually, type 2 q1-2 years)</i>			
	Retinopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Severity/comments			
Neuropathy	Symptoms <i>(Paresthesia/pain/numbness, GI symptoms, ED, diabetic foot complications)</i>			
	Diabetic foot exam done today <i>Record details in exam section</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Peripheral neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical exam	Weight (kg)			
	BP <i>(target 130/80)</i>			
	Heart rate/rhythm			
	Diabetic foot exam			
	Other exam findings			
Vaccines	Vaccines reviewed Details/comments <i>(Check EHR viewer for vaccine status)</i>			

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		Date:	Date:	Date:
CVD medications	Statin <i>(Indicated in all people with CAD+DM unless contraindicated or documented adverse effects; then consider other lipid-lowering agents)</i>	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford
	ACEi/ARB <i>(ACE inhibitor or ARB indicated indefinitely unless contraindicated)</i>	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford
	Beta blocker <i>(Indicated for all patients with normal LV function for minimum 3 years following ACS/MI unless contraindicated; specific beta-blockers recommended if reduced LVEF with prior MI or heart failure)</i>	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford	Indicated: <input type="checkbox"/> Continue <input type="checkbox"/> Start <input type="checkbox"/> No - not appropriate <input type="checkbox"/> No - not tolerated <input type="checkbox"/> No - indicated, declined <input type="checkbox"/> No - unable to afford
	Consider SGLT2i and/or GLP1a <i>- for cardiorenal benefit independent of glycemic control</i>			
	Antiplatelet agent <i>(Low-dose ASA indefinitely unless OAC indicated; dual antiplatelet therapy (DAPT) recommended for minimum 12 months after ACS and/or PCI)</i>	<input type="checkbox"/> ASA <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Other	<input type="checkbox"/> ASA <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Other	<input type="checkbox"/> ASA <input type="checkbox"/> Clopidogrel <input type="checkbox"/> Other
	Review DAPT indication/ongoing use	<input type="checkbox"/> N/A <input type="checkbox"/> Done	<input type="checkbox"/> N/A <input type="checkbox"/> Done	<input type="checkbox"/> N/A <input type="checkbox"/> Done
	CV medication adherence/comments/notes			
Management Plan	Patient goals/self-management			
	Advance care planning <i>(Discuss as needed; provide resources)</i>			
	Referrals for education/nutrition/exercise			
	Referrals to medical specialists			
	Assessment and management plan <i>(Changes to medications, resources provided to patient, etc.)</i>			
For CDM QIP online resources/handouts, information points for aspects of care, and details of CDM QIP indicators – https://www.ehealthsask.ca/services/CDM/Pages/default.aspx				