

Diabetes Education Checklist

Patient Information

Last Name

First Name

Date of Birth (yyyy/mm/dd)

Telephone Number

Date of Diabetes Education

Pharmacy Name

Pharmacist Name

Assessment / Visit Details

MedsCheck for Diabetes (Annual) available for review / attached

DTP identified and resolved, if applicable

Weight

Height

Waist circumference

BMI

Tobacco

Yes

No

cig/day

Alcohol / recreational drug use

Frequency of use

Dietary concerns / other notes

General Diabetes Education - Lifestyle / Health & Wellness

Management of medications (Rx, OTCs, herbals, vitamins)

Mental health assessment

Foot care discussion

Erectile dysfunction / sexual health

Screening for diabetic neuropathy

Lifestyle: diet, stress reduction, exercise

Foot condition / ulcers

Eye health and yearly eye exam reminder

Proper shoe fit

Dental hygiene

Blood pressure monitoring

Immunizations

Cardiovascular and other risk factors

Lifestyle / health & wellness notes

Diabetes Education Checklist

Blood Sugar Management

- | | |
|--|-------------------|
| <input type="checkbox"/> Blood glucose monitoring technique | Notes / follow-up |
| <input type="checkbox"/> Target blood glucose range reviewed | Notes / follow-up |
| <input type="checkbox"/> Hypoglycemia recognition and treatment | Notes / follow-up |
| <input type="checkbox"/> Hyperglycemia / sick day management | Notes / follow-up |
| <input type="checkbox"/> A1C awareness | Notes / follow-up |
| <input type="checkbox"/> Medication timing and adherence | Notes / follow-up |
| <input type="checkbox"/> Insulin injection technique / site rotation | Notes / follow-up |
| <input type="checkbox"/> Sharps disposal | Notes / follow-up |
| <input type="checkbox"/> Glucagon / emergency plan | Notes / follow-up |
| <input type="checkbox"/> Driving / occupational safety discussion | Notes / follow-up |

Supplies / Resources / Referrals

- | | |
|--|---------|
| <input type="checkbox"/> Meter / CGM / sensor education | Details |
| <input type="checkbox"/> Test strips / lancets / needles / syringes | Details |
| <input type="checkbox"/> Foot care resource provided | Details |
| <input type="checkbox"/> Diet / nutrition resource provided | Details |
| <input type="checkbox"/> Diabetes education program referral | Details |
| <input type="checkbox"/> Primary care provider referral / notification | Details |
| <input type="checkbox"/> Other resource or contact provided | Details |

Education topics discussed / identified for follow-up education

Prepared By

Pharmacist Full Name

Pharmacist's Signature

Date (yyyy/mm/dd)

Patient / Agent Signature, if used