nova scotia health authority | IWK Health Centre

Yarmouth Regional Hospital

YR00125604 DOB: Jan/1/1971 AGE: 044Y
TESTEFR,TEST M
123 STREET P O BOX 123
NEW GLASGOW, NS B2H 5C7
Pt. Home Phone: (902)999−9999 UPHI:
FIN CLASS: DOH INS.#: EXPIRY:
FD: TEST,DOCTOR 3 BNCWJDBVCJK MDNN
AD: TEST, NON−DOCTOR
REG: Jan/8/2015 AJ0000175/14

Diabetes Care Program of Nova Scotia

DIABETES PREGNANCY FLOW SHEET

Name (last, first): _____

Type of Diabetes: ❑ T1 ❑ T2 ❑ GDM ❑ Prediabetes **Date of Diagnosis** (YYYY−MM−DD): _____

Height: _____ **Pre−Pregnancy Weight:** _____ **Pre−Pregnancy BMI:** _____

Target Pregnancy Weight Gain: _____ **LNMP:** _____ **EDC (YYYY−MM−DD):** _____

GDM diagnostic values: **Date** (YYYY−MM−DD): _____ **Date** (YYYY−MM−DD): _____

50−g Glucose Challange (1−hr value): _____ 75−g OGTT (Fasting): _____ 1−hr: _____ 2−hr: _____

DATE (YYYY−MM−DD):→				
Lab Only ✓				
Seen by: (note: O = "other")	❑ RN ❑ RD ❑ NP ❑ MD ❑ O: _____	❑ RN ❑ RD ❑ NP ❑ MD ❑ O: _____	❑ RN ❑ RD ❑ NP ❑ MD ❑ O: _____	❑ RN ❑ RD ❑ NP ❑ MD ❑ O: _____
Weeks Gestation:				
Weight: Kg/lbs | Wt. Change	Kg/lbs | Wt. Change	Kg/lbs | Wt. Change	Kg/lbs | Wt. Change	Kg/lbs | Wt. Change
Blood Pressure:	1st | 2nd | Avg	1st | 2nd | Avg	1st | 2nd | Avg	1st | 2nd | Avg
BP Medication:	❑ Yes ❑ No ❑ ▲ ❑ See Med Sheet	❑ Yes ❑ No ❑ ▲ ❑ See Med Sheet	❑ Yes ❑ No ❑ ▲ ❑ See Med Sheet	❑ Yes ❑ No ❑ ▲ ❑ See Med Sheet
Foot Assessment: indicate risk rating and completed by: If Foot Clinic, date of exam: (YYYY−MM−DD)	❑ H ❑ DC ❑ M ❑ Foot Clinic ❑ Low ❑ MD/NP	Comments:		
BLOOD GLUCOSE (Capillary on left/lab right)				
Fasting (cap|lab)	cap | lab	cap | lab	cap | lab	cap | lab
2−hr/other (note)				
QA (within 15−20%)				
LABORATORY				
A1C % | Goal A1C %	Goal	Goal	Goal	Goal
TSH/Free T4				
BUN/Creatinine	BUN | Creat	BUN | Creat	BUN | Creat	BUN | Creat
u−ACR				
Ketones				
Other:				
Other:				
NOTES:				
Completed by (initials):				

Key: ❑ ▲ = Change

Continued on page 2...

nova scotia health authority | IWK Health Centre

Yarmouth Regional Hospital

YR00125604 DOB: Jan/1/1971 AGE: 044Y
TESTEFR,TEST M
123 STREET P O BOX 123
NEW GLASGOW, NS B2H 5C7
Pt. Home Phone: (902)999−9999 UPHI:
FIN CLASS: DOH INS.#: EXPIRY:
FD: TEST,DOCTOR 3 BNCWJDBVCJK MDNN
AD: TEST, NON−DOCTOR
REG: Jan/8/2015 AJ0000175/14

Diabetes Care Program of Nova Scotia

DIABETES PREGNANCY FLOW SHEET

Local Pharmacy: _____ Telephone: _____

Coverage: ❑ Private Insurance: _____ ❑ Pharmacare ❑ None

DATE (YYYY−MM−DD):→				
TREATMENT				
Insulin/ Non−insulin Therapies	❑ N/A ❑ ▲	❑ N/A ❑ ▲	❑ N/A ❑ ▲	❑ N/A ❑ ▲
	❑ Pump NSIPP: ❑ Yes ❑ No	❑ Pump NSIPP: ❑ Yes ❑ No	❑ Pump NSIPP: ❑ Yes ❑ No	❑ Pump NSIPP: ❑ Yes ❑ No
(✓ "pump")	TTD=_____ ;_____ u/Kg	TTD=_____ ;_____ u/Kg	TTD=_____ ;_____ u/Kg	TTD=_____ ;_____ u/Kg
Referrals/seen by:	Obstetrician: ❑ Already seeing ❑ Needs referral		Internal Medicine: ❑ Already seeing ❑ Needs referral	
Nutrition Therapy	❑ ▲	❑ ▲	❑ ▲	❑ ▲
Type of (#1−#9):	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
Adherence (#1−#5):	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Prenatal vitamins:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Type: 1. Diabetes Food Guide 2. General, Low Sodium, Low Fat 3. Beyond Basics (indicate calories) 4. CHO Counting 5. Low Sodium (less than 1700 mg) 6. Renal (Low potassium, low protein) 7. Lipid Lowering 8. Just the Basics 9. DASH (Hypertension)

Adherence: 1. Follows as recommended 2. Follows greater than or equal to 4 days/week 3. Unable/unwilling to follow 4. Revised 5. Has made some changes, but needs to continue to improve

Physical Activity • **Aerobic (A)** • **Resistance (R)** **Indicate quality (#1−5)**	A ❑ ▲ 1 2 3 4 5 | R ❑ ▲ 1 2 3 4 5	A ❑ ▲ 1 2 3 4 5 | R ❑ ▲ 1 2 3 4 5	A ❑ ▲ 1 2 3 4 5 | R ❑ ▲ 1 2 3 4 5	A ❑ ▲ 1 2 3 4 5 | R ❑ ▲ 1 2 3 4 5
Exercise Vital Sign (EVS) or Sessions/week	EVS: | # sessions/week:	EVS: | # sessions/week:	EVS: | # sessions/week:	EVS: | # sessions/week:
NOTES:				

Quality of PA: 1. Consistant, moderate or greater intesity: (A) aerobic: greater than or equal to 150 minutes/week; (R) Resistance: free weights or machines at least 2x/week
2. Regular, but less than recommended; (A) aerobic: regular PA but less than 150 min/week; (R) resistance: regular resistamce activities using resistance bands or body weight but less than 2x/wk
3. Irregular activity 4. Able, but not attempt 5. Limited due to medical limitations

Completed by (initials):				

Key: ❑ ▲ = Change

Continued on page 3...

nova scotia health authority | IWK Health Centre

Yarmouth Regional Hospital

YR00125604 DOB: Jan/1/1971 AGE: 044Y
TESTEFR,TEST M
123 STREET P O BOX 123
NEW GLASGOW, NS B2H 5C7
Pt. Home Phone: (902)999−9999 UPHI:
FIN CLASS: DOH INS.#: EXPIRY:
FD: TEST,DOCTOR 3 BNCWJDBVCJK MDNN
AD: TEST, NON−DOCTOR
REG: Jan/8/2015 AJ0000175/14

Diabetes Care Program of Nova Scotia

DIABETES PREGNANCY FLOW SHEET

SELF−CARE PRACTICES

Diabetes Distress (assessed YYYY−MM−DD):	❑ Low 1−2 ❑ Mod 2−2.9 ❑ High Greater than or equal to 3	Comments: ❑ Referred

DATE (YYYY−MM−DD): →				
SELF−CARE PRACTICES				
SMBG • Frequency: • Use of results: • Appropriate Technique: **Comments:**	❑ n/a 1 2 3 4 5 6 7 1 2 3 4 ❑ Yes ❑ No ❑ Reviewed	❑ n/a 1 2 3 4 5 6 7 1 2 3 4	❑ n/a 1 2 3 4 5 6 7 1 2 3 4	❑ n/a 1 2 3 4 5 6 7 1 2 3 4

Frequency: 1. Regular as recommended 2. Regular less than recommended 3. Only when feeling poor 4. Does not test 5. At least 4x/day 6. Approp. High intensity 7. Approp. Low intensity
Use: 1. Uses to modify treatment/act on results 2. Understands/does not adjust 3. Incorrect interpretation/incorrect modification 4. Does not use results

Adverse Glycemic Events (since last visit, indicate frequency)	❑ None ❑ Mild x _____ ❑ Mod x _____ ❑ Severe x _____ ❑ DKA x _____ ❑ Reviewed appropriate Tx	❑ None ❑ Mild x _____ ❑ Mod x _____ ❑ Severe x _____ ❑ DKA x _____ ❑ Reviewed appropriate Tx	❑ None ❑ Mild x _____ ❑ Mod x _____ ❑ Severe x _____ ❑ DKA x _____ ❑ Reviewed appropriate Tx	❑ None ❑ Mild x _____ ❑ Mod x _____ ❑ Severe x _____ ❑ DKA x _____ ❑ Reviewed appropriate Tx
Ketones (appropriate testing)	❑ Yes ❑ No ❑ Reviewed	❑ Yes ❑ No ❑ Reviewed	❑ Yes ❑ No ❑ Reviewed	❑ Yes ❑ No ❑ Reviewed
Smoking (indicate date quit)	❑ Yes ❑ No ❑ Quit If yes: ❑ Referred ❑ Info. given	If quit, when? _____ (YYYY−MM−DD)	Comments:	

Eye Exam (YYYY−MM):→	**Dental Exam** (YYYY−MM):→	**Diabetes ID:** ❑ Yes ❑ No

Goal/Action Plan (reviewed) **NOTES:**	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Progress Notes (✓)				
Completed by (initials):				

Print Name	Signature	Initials	Print Name	Signature	Initials