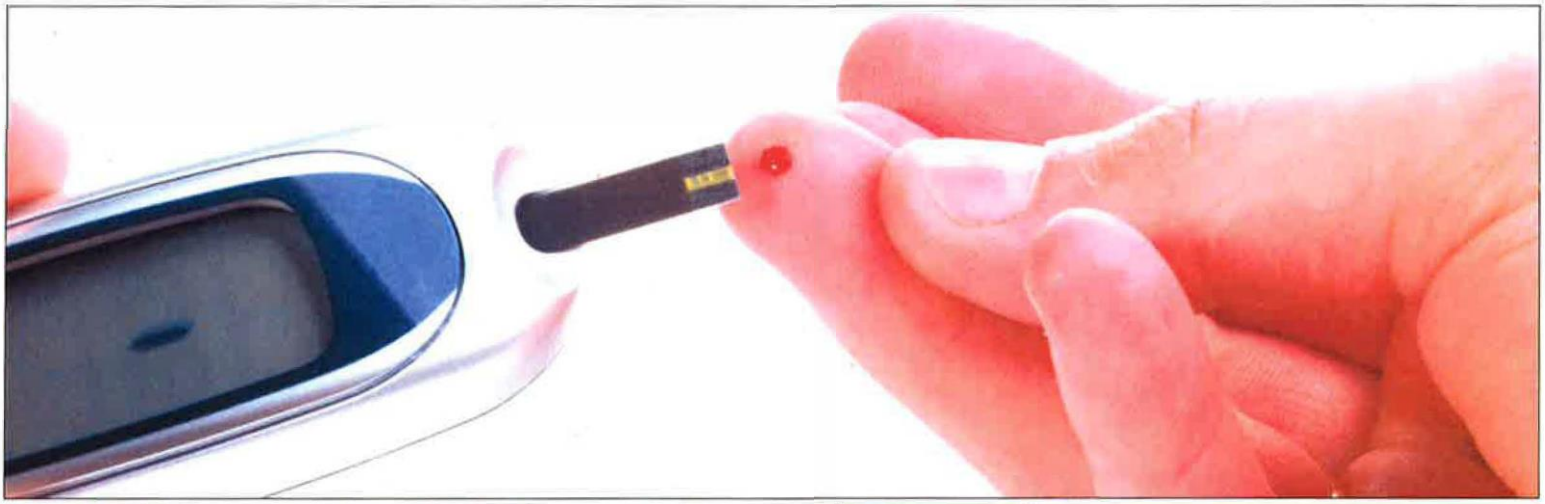
DIABETES ACTION PLAN

Name: _____

Medical Provider's	Clinical Case Manager's
Name: _____	Name: _____
Phone: _____	Phone: _____



THINGS TO DO EVERYDAY:

D Check my blood sugar (fill in chart below with your medical provider)

D Check my feet for sores or redness

D Wear shoes and socks that fit well

D Take all of my medicine as directed, even when I feel well

D Follow my meal plan

D Be active

D Talk to my medical provider if I am having problems or have questions about my diabetes

TESTING MY BLOOD SUGAR:

I plan to test my blood sugar____ times per day.

	Before	Hour(s) After
Breakfast		
Lunch		
Dinner		
Bedtime		

My target blood sugars are:

Mornings:	Before Meals:
After Meals:	Bedtime:

MY PLAN:

Discuss with my medical provider

D Meal Plan

D Activity/Exercise Plan

D Smoking

D Medical Alert bracelet

D Medicine changes based on blood sugar results

D Eye exam by eye doctor

D ACEI/ARB medication

D Statin

D Hepatitis B vaccine

D Pneumonia vaccine

D Yearly foot exam by doctor

D Yearly flu vaccine

D Urine test for protein

D Aspirin

D LDL Testing

D Daily foot care

GOALS:

Date:	My Weight:	My Goal:
Date:	My Blood Pressure:	My Goal:
Date:	My Blood Sugar:	My Goal:
Date:	My LDL Cholesterol:	My Goal:
Date:	My A1C:	My Goal:

Last Lipid Profile done:	Next Lipid Profile due:
Last A1C done:	Next A1C due:

DIABETES ACTION PLAN

I WILL CALL MY MEDICAL PROVIDER TODAY IF:

D My blood sugar is over _____

D My blood sugar is less than _____

D I have chest pain or tightness

D I feel weak or have tingling on one side of my body

D I have new eye problems, or my eye problems get worse

D I have new speech problems

D I have new sores or redness on my feet

D I feel dizzy or confused

D I feel thirsty more than usual

D I need to urinate more than usual

D I am having a problem with or have questions about my medicine

I WILL CALL 911 IF:

D I have chest, throat or arm tightness or pressure with or without shortness of breath, a cold sweat or nausea

D I have sudden weakness or numbness of my face, arm or leg

D I have sudden Confusion, trouble speaking or understanding others

D I have sudden loss of balance, dizziness or difficulty seeing

MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)

Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ | 6 ○ | 7 ○ | 8 ○ | 9 ○ | 10 ○ | Totally important

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ | 6 ○ | 7 ○ | 8 ○ | 9 ○ | 10 ○ | Totally confident

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or email and date/time):