

REMINDER: BRING THIS CARD WITH YOU TO ALL DOCTOR APPOINTMENTS

Checkpoints	ACE Standards		Patient Goals*	Date	Date	Date	Date	Date
	Goal	How Often						
Blood Pressure	< 130/80	Every Visit						
Foot Exam		Every Visit						
Weight/BMI	BMI < 25	Every Visit						
A1C	≤ 6.5%	Quarterly						
Eye Exam (Dilated)	None, NPDR, PDR, ME, Other. Physician to fill-in.	Yearly	Laser Y N	Laser Y N	Laser Y N	Laser Y N	Laser Y N	Laser Y N
HDL	> 40 mg/dl	Yearly						
LDL Cholesterol	< 70 mg/dl	Yearly						
Triglycerides	< 150 mg/dl	Yearly						
Urine Test (Microalbumin)		Yearly						
Diabetes Education	Annual Refresher	As Needed						
Nutritional Counseling	Annual Refresher	As Needed						
Self Monitoring Blood Glucose	B <110 , A <140 mg/dl	As Needed						

*Goals are based on current AACE guidelines or from current available evidence for each risk factor. Check with your physician to select your appropriate goals.

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DIABETES TEAM INFORMATION

Doctor: _____ Phone: _____
 Educator: _____ Phone: _____
 Dietician: _____ Phone: _____
 Pharmacist: _____ Phone: _____
 Foot Doctor: _____ Phone: _____
 Eye Doctor: _____ Phone: _____
 Dentist: _____ Phone: _____

Adapted from Cleveland Clinic
Diabetes Passport.

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DIABETES PASSPORT



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DEFINITIONS AND EXPLANATIONS

A1C: Blood test that measures how well your blood sugar has been controlled over the previous few months.
BMI: Body Mass Index a number that shows body weight adjusted for height. Visit www.powerofprevention.com to calculate your BMI.
Eye Exam: Have your eye doctor complete this section.
 P = Proliferative NP = Non-Proliferative
 ME = Macular Edema DR = Diabetic Retinopathy
Foot Exam: Check your feet daily and show your doctor any areas of concern, like sores that don't heal.
Self Monitoring Blood Glucose: Main method for checking your blood sugar at any one time.
 B = Before eating (pre-prandial)
 A = After eating (two-hour post-prandial)
Yearly: At least once a year or more often if determined by you physician.

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Medications
(Name, dose, frequency)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies:

Medications
(Name, dose, frequency)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies: