PLANNED CARE MODEL PATIENT FLOW SHEET

Name:_____ **DOB:** _____ **Sex: M □ F □ ID#**_____

PMHx **CVD, Depression, DM 1 or 2, Dyslipidemia, HTN, Nephrop, Neurop, Retinop**								
	Date	**Result**	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**
Vital Signs								
Weight/Height/BMI (BMI 18.5-24.9kg/m2)								
BP (<130/80)								
Pulse (<100 beats/min)								
Tobacco Use		**Yes/No**		**Yes/No**		**Yes/No**		**Yes/No**
Advised to quit		**Yes/No/NA**		**Yes/No/NA**		**Yes/No/NA**		**Yes/No/NA**
Assessed Readiness		**Yes/No/NA**		**Yes/No/NA**		**Yes/No/NA**		**Yes/No/NA**
Lab Tests and Other Studies								
LDL (<100 mg/dL)								
HDL (>60 mg/dL)								
Triglycerides (≤150 mg/dL)								
Microalb/cr (DM1/2) (Screen annually if no dx of nephropathy)								
HbA1c (if diabetic) (HbA1c <7.0%)								
Dilated Eye Exam (Annually if diabetic)								
Risk Assessment/Counseling/Education								
Exercise								
Nutrition								
Depression screening								
Foot Exam								
Immunization: Flu Shot (Annually)								
Immunizations: Pneumovax (high risk pts OR once after 65)								
Immunizations: Tb								
Self-management goal								
Medications								
Category/name		**Changed?**		**Changed?**		**Changed?**		**Changed?**
ASA/Anti-thrombolytic _____	**Yes No**		**Yes No**		**Yes No**		**Yes No**	
ACE inhibitor _____	**Yes No**		**Yes No**		**Yes No**		**Yes No**	
Beta Blocker_____ (Minimum-Add after CV event)	**Yes No**		**Yes No**		**Yes No**		**Yes No**	
Statin _____	**Yes No**		**Yes No**		**Yes No**		**Yes No**	
Antidepressant _____	**Yes No**		**Yes No**		**Yes No**		**Yes No**	
Hypoglycemic agent_____	**Yes No**		**Yes No**		**Yes No**		**Yes No**	
Other _____	**Yes No**		**Yes No**		**Yes No**		**Yes No**	

KEY: √ completed areas N/A = Not applicable/indicated Additional notes/comments in the progress notes section