

# Essential Communication Elements Diabetes Checklist

Diabetes diagnosis, including subtype classification	YES <input type="checkbox"/> NO <input type="checkbox"/>
Duration of diabetes (new diagnosis or chronic)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Recent blood glucose values along with blood glucose monitoring schedule with date and time for when the next blood glucose value is due	YES <input type="checkbox"/> NO <input type="checkbox"/>
Target range for blood glucose	YES <input type="checkbox"/> NO <input type="checkbox"/>
History of hypoglycemic episodes	YES <input type="checkbox"/> NO <input type="checkbox"/>
Current antihyperglycemic drug regimen	YES <input type="checkbox"/> NO <input type="checkbox"/>
Recent changes in the antihyperglycemic drug regimen	YES <input type="checkbox"/> NO <input type="checkbox"/>
Identification of and associated rationale for sliding scale insulin order initiated during hospitalization	YES <input type="checkbox"/> NO <input type="checkbox"/>
Current diet including whether it is administered via enteral feeding tube and if so, the schedule should be provided	YES <input type="checkbox"/> NO <input type="checkbox"/>
Age	YES <input type="checkbox"/> NO <input type="checkbox"/>
Presence of surgical interventions or trauma/tissue damage	YES <input type="checkbox"/> NO <input type="checkbox"/>
Presence of dementia	YES <input type="checkbox"/> NO <input type="checkbox"/>
Presence of delirium if known	YES <input type="checkbox"/> NO <input type="checkbox"/>
Last value and date of renal assessment	YES <input type="checkbox"/> NO <input type="checkbox"/>
Current non-antihyperglycemic drug list	YES <input type="checkbox"/> NO <input type="checkbox"/>
Details of systemic glucocorticoid therapy, if applicable	YES <input type="checkbox"/> NO <input type="checkbox"/>
Assessment of patient ability to self-administer current diabetes regimen	YES <input type="checkbox"/> NO <input type="checkbox"/>
If self-monitoring is ordered, assessment of patient ability to self-monitor blood glucose.	YES <input type="checkbox"/> NO <input type="checkbox"/>
Assessment of patient ability to self-identify and report signs/symptoms of hyper and hypoglycemia	YES <input type="checkbox"/> NO <input type="checkbox"/>
Provision of educational materials to patient	YES <input type="checkbox"/> NO <input type="checkbox"/>
Assessment of patient/caregiver understanding of the education	YES <input type="checkbox"/> NO <input type="checkbox"/>
If applicable, a post-discharge appointment should be scheduled with the diabetes management prescriber/ physician or endocrinologist	YES <input type="checkbox"/> NO <input type="checkbox"/>