1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: DIABETES MANAGEMENT CONSULTATION / FOLLOW-UP / MEDICATION MANAGEMENT / INSULIN ADJUSTMENT / CGM REVIEW / PUMP REVIEW / HOSPITAL FOLLOW-UP / TELEHEALTH

CARE SETTING: OUTPATIENT / ENDOCRINOLOGY CLINIC / DIABETES CLINIC / PRIMARY CARE / HOSPITAL FOLLOW-UP / TELEHEALTH

DIABETES TYPE: TYPE 1 / TYPE 2 / GESTATIONAL / LADA / MODY / SECONDARY DIABETES / OTHER

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING PROVIDER, IF APPLICABLE

DIABETES EDUCATOR, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

Document the primary diabetes-related reason for the visit in the patient's own words when possible, including diabetes follow-up, hyperglycemia, hypoglycemia, insulin adjustment, medication management, CGM review, insulin pump review, A1c review, diabetes complications, gestational diabetes follow-up, new diabetes diagnosis, uncontrolled diabetes, or post-hospital diabetes management.

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

Document patient-reported diabetes history, glucose patterns, medication use, lifestyle factors, complications, comorbidities,

and barriers to care.

3a VISIT CONTEXT & GLYCEMIC CONTROL

Reason for Diabetes Management Visit:

Document whether the visit is for initial diabetes evaluation, routine follow-up, uncontrolled diabetes, hypoglycemia evaluation, hyperglycemia management, medication adjustment, insulin initiation, insulin titration, CGM review, insulin pump management, diabetes education, pregnancy-related diabetes care, or post-hospital follow-up.

Diabetes History:

Document diabetes type, year or age at diagnosis, initial presentation, prior DKA/HHS, prior hospitalizations, prior diabetes education, diabetes complications, prior treatment regimens, and overall disease trajectory.

Current Glycemic Control:

Document recent glucose trends, fasting glucose, postprandial glucose, bedtime glucose, overnight glucose, variability, time in range when available, A1c trend, hyperglycemia frequency, hypoglycemia frequency, and patient perception of control.

Hyperglycemia Symptoms:

Document polyuria, polydipsia, polyphagia, fatigue, blurred vision, weight loss, dehydration, nausea, vomiting, abdominal pain, ketone testing, sick-day symptoms, and possible DKA/HHS warning symptoms.

Hypoglycemia Symptoms:

Document shakiness, sweating, palpitations, confusion, dizziness, weakness, hunger, headache, nightmares, seizures, loss of consciousness, hypoglycemia unawareness, timing, triggers, treatment, glucagon availability, and severe episodes requiring assistance.

Home Glucose Monitoring:

Document glucometer use, testing frequency, glucose log availability, CGM use, sensor wear time, alerts, calibration needs, fingerstick confirmation, data sharing, supply access, and barriers to monitoring.

Continuous Glucose Monitor Review, if applicable:

Document CGM device, wear percentage, time in range, time above range, time below range, glucose management indicator, average glucose, coefficient of variation, nocturnal trends, postprandial excursions, hypoglycemia patterns, and data limitations.

3b THERAPY

Insulin Therapy, if applicable:

Document basal insulin, bolus insulin, correction scale, insulin-to-carbohydrate ratio, insulin sensitivity factor, timing of doses, missed doses, injection sites, rotation, lipohypertrophy, pen/syringe use, storage, affordability, and hypoglycemia risk.

Insulin Pump Therapy, if applicable:

Document pump model, basal profile, bolus settings, correction factor, insulin-to-carbohydrate ratio, active insulin time, infusion site changes, occlusions, alarms, pump downloads, automated insulin delivery use, backup insulin plan, and supply access.

Non-Insulin Diabetes Medication History:

Document metformin, GLP-1 receptor agonists, dual incretin therapy, SGLT2 inhibitors, DPP-4 inhibitors, sulfonylureas, thiazolidinediones, alpha-glucosidase inhibitors, meglitinides, amylin analogs, adherence, response, side effects, contraindications, and cost/access barriers.

Medication Adherence and Administration:

Document missed doses, timing issues, refill gaps, side effects, misunderstanding of regimen, injection technique, medication storage, access barriers, insurance barriers, pharmacy issues, and caregiver involvement when relevant.

3c LIFESTYLE & COMPLICATIONS

Nutrition / Meal Pattern:

Document meal timing, carbohydrate intake, carbohydrate counting, portion sizes, sugary drinks, snacks, late-night eating, food insecurity, cultural dietary patterns, diet attempts, nutrition counseling, and barriers to dietary change.

Physical Activity:

Document exercise frequency, type, duration, intensity, sedentary time, activity-related hypoglycemia, limitations due to pain or comorbidities, and activity goals.

Weight / Metabolic Context:

Document weight change, appetite, obesity or underweight concerns, bariatric surgery history, anti-obesity medication use, sleep patterns, stress, and metabolic comorbidities.

Diabetes Complications:

Document neuropathy, nephropathy, retinopathy, cardiovascular disease, peripheral vascular disease, gastroparesis, erectile dysfunction, recurrent infections, foot ulcers, amputations, dental disease, and skin complications.

Eye Health:

Document last dilated eye exam, retinopathy history, vision changes, ophthalmology follow-up, injections/laser history, and planned eye care.

Kidney Health:

Document albuminuria, chronic kidney disease, renal function trends, nephrology involvement, ACE inhibitor/ARB use when relevant, edema, foamy urine, and kidney-protective medication considerations.

Neuropathy / Foot Symptoms:

Document numbness, tingling, burning, pain, loss of sensation, ulcers, calluses, foot deformity, infections, footwear, podiatry care, and daily foot checks.

Cardiovascular Risk:

Document hypertension, hyperlipidemia, coronary artery disease, stroke/TIA, peripheral artery disease, smoking/nicotine use, statin use, aspirin use when relevant, blood pressure control, and family history of premature cardiovascular disease.

Pregnancy / Reproductive Considerations, if applicable:

Document pregnancy status, pregnancy intentions, contraception, gestational diabetes history, preconception A1c goals, medication safety, fetal/maternal risk counseling, and OB/MFM involvement when relevant.

Sick-Day / Safety History:

Document illness-related glucose changes, ketone testing, hydration, medication holds, emergency plan, glucagon use, DKA prevention, and understanding of when to seek urgent care.

Past Medical and Surgical History:

Include diabetes-related comorbidities, obesity, hypertension, hyperlipidemia, kidney disease, liver disease, heart disease, stroke, pancreatitis, thyroid disease, autoimmune disease, bariatric surgery, pregnancy-related complications, or hospitalizations.

Family History:

Document family history of diabetes, obesity, premature cardiovascular disease, kidney disease, thyroid disease, autoimmune disease, or inherited diabetes syndromes.

Social / Lifestyle History:

Document occupation, schedule, shift work, food access, housing stability, alcohol use, tobacco/nicotine use, substance use, exercise access, caregiver support, medication affordability, technology access, and barriers to diabetes self-management.

Pertinent Negatives:

Document denial of red-flag symptoms when clinically relevant, including severe hypoglycemia, loss of consciousness, seizure, persistent vomiting, abdominal pain, ketones, confusion, severe dehydration, chest pain, acute neurologic deficit, foot ulcer, fever, or rapidly worsening hyperglycemia.

ROS DIABETES REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Document pertinent positives and negatives:

Polyuria, polydipsia, polyphagia, fatigue, blurred vision, weight change, or dehydration symptoms

Hypoglycemia symptoms, hypoglycemia unawareness, nocturnal hypoglycemia, seizure, or loss of consciousness

Nausea, vomiting, abdominal pain, ketones, confusion, or DKA/HHS symptoms

Numbness, tingling, burning pain, foot ulcers, calluses, infections, or poor wound healing

Vision changes, retinopathy symptoms, eye pain, or ophthalmology concerns

Chest pain, palpitations, dyspnea, edema, claudication, or cardiovascular symptoms

Foamy urine, edema, hypertension, decreased urine output, or kidney-related symptoms

Medication side effects, injection-site issues, device problems, supply barriers, or adherence concerns

O OBJECTIVE

5 EXAMINATION

Document observed diabetes-relevant findings and examination details.

5a VITALS

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

HEIGHT

WEIGHT

BMI

WAIST CIRCUMFERENCE, IF APPLICABLE

PAIN SCORE, IF APPLICABLE

5b EXAMINATION

General Appearance:

Document alertness, distress level, hydration status, body habitus, mobility, and overall clinical condition.

Head / Eyes / Ears / Nose / Throat:

Document visual concerns, oral mucosa, hydration status, dental findings, and findings relevant to diabetes complications when assessed.

Neck:

Document thyroid enlargement, lymphadenopathy, acanthosis-related findings, or other endocrine findings when relevant.

Cardiovascular:

Document rate, rhythm, murmurs, edema, pulses, perfusion, capillary refill, and signs of cardiovascular or peripheral vascular disease.

Pulmonary:

Document respiratory effort, breath sounds, and findings relevant to infection, obesity, cardiometabolic disease, or acute metabolic illness.

Abdomen:

Document tenderness, distension, hepatomegaly, injection sites, surgical scars, lipohypertrophy, and bariatric surgery-related findings when relevant.

Extremities / Vascular:

Document peripheral pulses, edema, skin temperature, hair loss, capillary refill, cyanosis, wounds, ulcers, deformities, and peripheral artery disease signs.

Foot Examination:

Document inspection, calluses, ulcers, skin breakdown, fungal changes, deformities, Charcot changes, pulses, monofilament testing, vibration sensation, proprioception, pinprick sensation, footwear, and podiatry needs.

Skin / Injection Sites:

Document acanthosis nigricans, lipohypertrophy, lipoatrophy, bruising, injection-site reactions, CGM/pump site irritation, infections, wounds, ulcers, and healing status.

Neurologic:

Document mental status, gait, sensation, reflexes, strength, neuropathy findings, and focal deficits when relevant.

Psychiatric:

Document mood, affect, diabetes distress, anxiety, depression symptoms, cognition, insight, judgment, and ability to participate in self-management.

GD GLYCEMIC DATA / DEVICE REVIEW

6 DATA REVIEWED

Document diabetes data reviewed during the visit. Include:

A1C AND TREND

FINGERSTICK GLUCOSE LOG

CGM REPORT AND DATE RANGE

TIME IN RANGE

TIME ABOVE RANGE

TIME BELOW RANGE

AVERAGE GLUCOSE

GLUCOSE MANAGEMENT INDICATOR

GLYCEMIC VARIABILITY

NOCTURNAL TRENDS

FASTING TRENDS

POSTPRANDIAL TRENDS

HYPOGLYCEMIA EPISODES

INSULIN PUMP DOWNLOAD WHEN APPLICABLE

INSULIN DELIVERY PATTERNS

MISSED BOLUSES OR LATE BOLUSES

SENSOR/PUMP LIMITATIONS

INTERPRETATION AND CLINICAL ACTION TAKEN

CS DIABETES COMPLICATION SCREENING

7 SCREENING STATUS

Document screening status and findings. Include:

DILATED EYE EXAM DATE AND RETINOPATHY STATUS

URINE ALBUMIN/CREATININE RATIO

EGFR AND RENAL FUNCTION TREND

FOOT EXAM DATE AND FINDINGS

NEUROPATHY SCREENING

BLOOD PRESSURE CONTROL

LIPID PANEL AND STATIN STATUS

ASCVD HISTORY OR RISK ASSESSMENT

DENTAL CARE WHEN RELEVANT

VACCINATION STATUS WHEN RELEVANT

SMOKING/NICOTINE STATUS

SLEEP APNEA SCREENING WHEN RELEVANT

DEPRESSION/DIABETES DISTRESS SCREENING WHEN RELEVANT

MS MEDICATION / INSULIN SAFETY ASSESSMENT

8 SAFETY REVIEW

Document medication safety review. Include:

CURRENT DIABETES MEDICATIONS

DOSE, ROUTE, FREQUENCY, AND TIMING

ADHERENCE AND MISSED DOSES

SIDE EFFECTS AND CONTRAINDICATIONS

HYPOGLYCEMIA RISK

RENAL/HEPATIC DOSING CONSIDERATIONS

INJECTION TECHNIQUE

SITE ROTATION

INSULIN STORAGE

SICK-DAY MEDICATION HOLDS WHEN RELEVANT

PREGNANCY/LACTATION CONSIDERATIONS WHEN RELEVANT

DRUG INTERACTIONS

MEDICATION AFFORDABILITY AND ACCESS

REFILL NEEDS AND PRIOR AUTHORIZATION ISSUES

ST SCREENING / ASSESSMENT TOOLS

9 SCORES & INTERPRETATION

Document standardized tools used and interpretation, if applicable. Include: A1c · CGM time in range · Glucose management indicator · Hypoglycemia awareness assessment · Diabetes distress scale · PHQ-9 / GAD-7 when diabetes affects mood/function · ASCVD risk assessment · Foot risk classification · Monofilament testing · STOP-Bang when sleep apnea risk is relevant · Nutrition or carbohydrate-counting assessment · Medication adherence assessment. Include score, result, interpretation, comparison to prior results, and limitations.

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Document diabetes-relevant results reviewed or ordered. Include:

Glycemic Testing:

A1c, fasting glucose, random glucose, fructosamine, CGM metrics, glucometer data, ketones, and glucose logs.

Renal Monitoring:

Serum creatinine, eGFR, urine albumin/creatinine ratio, urinalysis, electrolytes, and nephrology results when applicable.

Cardiometabolic Labs:

Lipid panel, liver function, CMP, blood pressure trends, ASCVD risk markers, ApoB, lipoprotein(a) when indicated, and fatty liver-related testing.

Diabetes Classification Testing:

C-peptide, insulin level when relevant, GAD65 antibody, IA-2 antibody, ZnT8 antibody, islet cell antibody, MODY/genetic testing when indicated, and autoimmune screening when relevant.

Medication Safety Labs:

Renal function, liver function, electrolytes, B12 for metformin use when relevant, thyroid testing when indicated, pregnancy testing when relevant, and therapy-specific monitoring labs.

Complication Evaluation:

Eye exam reports, foot/podiatry reports, vascular studies, cardiac testing, neuropathy testing, nephrology records, wound care records, and dental records when relevant.

Hospital / Emergency Records:

DKA/HHS admission records, hypoglycemia event records, discharge summaries, insulin changes, infection records, and emergency department notes.

Prior Records Reviewed:

Primary care notes, endocrinology notes, diabetes education records, nutrition notes, ophthalmology notes, podiatry notes, nephrology notes, cardiology notes, hospital records, medication history, device downloads, and outside records.

A ASSESSMENT

11 DIABETES INTERPRETATION

Provide diabetes-specific clinical interpretation: Diabetes type and current control status · A1c and glucose pattern interpretation · Hypoglycemia and hyperglycemia risk assessment · Glycemic variability and device data interpretation when available · Medication response, adherence, side effects, contraindications, and access barriers · Diabetes complication status and screening gaps · Cardiovascular, renal, ophthalmologic, neurologic, vascular, foot, and metabolic risk considerations · Lifestyle, nutrition, physical activity, sleep, stress, work schedule, and social factors affecting diabetes management · Need for medication initiation, titration, insulin adjustment, CGM/pump change, diabetes education, nutrition referral, complication screening, specialist referral, hospitalization, or urgent escalation

P PLAN

12 MANAGEMENT BY PROBLEM

Outline diabetes management by problem. Include:

Glycemic management plan,

including A1c goal if individualized, glucose targets, monitoring frequency, CGM use, glucometer use, and interpretation of glucose patterns.

Medication plan,

including initiation, continuation, dose adjustment, discontinuation, refill needs, contraindications, side effects, renal/hepatic considerations, pregnancy considerations, and affordability/access support.

Insulin plan,

including basal dose, bolus strategy, correction scale, insulin-to-carbohydrate ratio, timing of insulin, hypoglycemia prevention, site rotation, storage, backup plan, and education when relevant.

Pump/CGM plan,

including setting changes, alert settings, data sharing, sensor wear, infusion site care, troubleshooting, supply coordination, and backup insulin plan when applicable.

Hypoglycemia plan,

including trigger reduction, medication adjustment, rule-of-15 education, glucagon prescription/education, driving/work safety, nocturnal hypoglycemia precautions, and emergency plan.

Hyperglycemia / sick-day plan,

including hydration, ketone testing, medication guidance, insulin correction plan, infection precautions, DKA/HHS warning signs, and when to seek urgent or emergency care.

Nutrition plan,

including carbohydrate consistency, carbohydrate counting when applicable, meal timing, portion guidance, protein/fiber intake, sugary drink reduction, culturally appropriate diet modifications, and dietitian referral when indicated.

Physical activity plan,

including exercise goals, activity-related glucose monitoring, hypoglycemia prevention, resistance training, walking goals, and limitations based on complications or comorbidities.

Weight and cardiometabolic plan,

including weight goals, anti-obesity medication consideration when appropriate, blood pressure management, lipid management, smoking cessation, sleep apnea screening, and cardiovascular risk reduction.

Complication screening plan,

including eye exam, kidney labs, foot exam, neuropathy screening, podiatry referral, dental care, wound care, and vascular/cardiology evaluation when indicated.

Pregnancy/reproductive plan,

including preconception A1c goal, medication safety, contraception, gestational diabetes follow-up, OB/MFM coordination, and pregnancy glucose targets when relevant.

Education and self-management plan,

including diabetes education, medication use, device use, injection technique, foot care, glucose monitoring, sick-day rules, travel/work planning, and caregiver education when relevant.

Referral and care coordination plan

with diabetes educator, dietitian, ophthalmology, podiatry, nephrology, cardiology, vascular surgery, wound care, bariatric medicine, behavioral health, primary care, OB/MFM, or emergency care when indicated.

Patient education

regarding diagnosis, glucose goals, medication adherence, monitoring, lifestyle measures, complication prevention, red flags, and when to seek urgent or emergency care.

F FOLLOW-UP

13 REASSESSMENT PLAN

Specify follow-up timeframe and purpose, including glucose review, CGM/pump review, medication titration, insulin adjustment, A1c monitoring, hypoglycemia follow-up, complication screening, lab review, diabetes education follow-up, nutrition follow-up, or urgent return precautions.

TB TIME DOCUMENTATION & BILLING

14 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT

DIABETES COUNSELING TIME

MEDICATION / INSULIN COUNSELING TIME

CGM / PUMP REVIEW TIME, IF APPLICABLE

NUTRITION / LIFESTYLE COUNSELING TIME, IF APPLICABLE

HYPOGLYCEMIA SAFETY COUNSELING TIME, IF APPLICABLE

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

LAB / DEVICE DATA REVIEW TIME, IF APPLICABLE

14a BILLING CONSIDERATIONS — E/M / DIABETES MANAGEMENT CODING

E/M LEVEL: [E.G., 99202 / 99203 / 99204 / 99205 / 99212 / 99213 / 99214 / 99215]

CGM INTERPRETATION CODE(S), IF APPLICABLE

INSULIN PUMP / DEVICE MANAGEMENT CODE(S), IF APPLICABLE

DIABETES EDUCATION / TRAINING CODE(S), IF APPLICABLE

MEDICATION MONITORING DOCUMENTATION, IF APPLICABLE

BASIS FOR BILLING: [TIME-BASED / MEDICAL DECISION MAKING / DEVICE DATA INTERPRETATION / MEDICATION MANAGEMENT / INSULIN ADJUSTMENT / CARE COORDINATION]

ICD-10 DIAGNOSIS CODES: [PRIMARY DIABETES DIAGNOSIS CODE + DESCRIPTION]

[SECONDARY HYPERGLYCEMIA / HYPOGLYCEMIA / COMPLICATION / MEDICATION MONITORING DIAGNOSIS CODE(S), IF APPLICABLE]

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: ENDOCRINOLOGY / DIABETES MANAGEMENT

DATE

TIME

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