

DIABETES ACTION PLAN

Name: _____

Medical Provider's

Name: _____

Phone: _____

Case Manager's

Name: _____

Phone: _____

Medical Social Worker's

Name: _____

Phone: _____



THINGS TO DO EVERYDAY:

- Check my blood sugar (fill in chart below with your medical provider)
- Check my feet for sores or redness
- Wear shoes and socks that fit well
- Take all of my medicine as directed, even when I feel well
- Follow my meal plan
- Be active
- 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

- Meal Plan
- Activity/Exercise Plan
- Smoking
- Medical Alert bracelet
- Medicine changes based on blood sugar results
- Eye exam by eye doctor
- ACEI/ARB medication
- Statin
- Hepatitis B vaccine
- Pneumonia vaccine
- Yearly foot exam by doctor
- Yearly flu vaccine
- Urine test for protein
- Aspirin
- LDL Testing
- 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:

- My blood sugar is over _____
- My blood sugar is less than _____
- I have chest pain or tightness
- I feel weak or have tingling on one side of my body
- I have new eye problems or my eye problems get worse
- I have new speech problems
- I have new sores or redness on my feet
- I feel dizzy or confused
- I feel thirsty more than usual
- I need to urinate more than usual
- I am having a problem with or have questions about my medicine

I WILL CALL 911 IF:

- I have chest, throat or arm tightness or pressure with or without shortness of breath, a cold sweat or nausea
- I have sudden weakness or numbness of my face, arm or leg
- I have sudden confusion, trouble speaking or understanding others
- 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):