hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

My Diabetes Action Plan

Take this form to your next appointment. Together, you and your doctor can create a plan to set and reach personalized goals.

MY CARE TEAM

My name: _____ Date: _____

Primary care provider (PCP): _____ Phone: _____

Diabetes doctor (endocrinologist): _____ Phone: _____

Certified diabetes educator: _____ Phone: _____

Registered dietitian: _____ Phone: _____

Foot doctor (podiatrist): _____ Phone: _____

Eye doctor (ophthalmologist or optometrist): _____ Phone: _____

Pharmacist: _____ Phone: _____

Emergency contact: _____ Phone: _____

MEDICATION MANAGEMENT

List all of your current medications below. Review this list with your doctor at every visit to decide if you need to make any changes.

Name of medication (e.g., metformin)	**How much to take** (e.g., 500 mg)	**When to take it** (e.g., twice a day, at breakfast and dinner)	**What it's for** (e.g., control blood sugar levels)

Mark the days and times you check your blood glucose per your doctor's instructions:

Days: ❏ Monday ❏ Tuesday ❏ Wednesday ❏ Thursday ❏ Friday ❏ Saturday ❏ Sunday

Times: ❏ Before breakfast ❏ After breakfast ❏ Before lunch ❏ After lunch ❏ Before dinner ❏ After dinner ❏ Bedtime ❏ Middle of the night

(See reverse side)

TRACK YOUR PROGRESS

Record your goals and track your results on this chart.

Test or service (frequency)	**Target**	**My goal**	**Date/Result**	**Date/Result**	**Date/Result**	**Date/Result**
A1c (every three to six months)	Less than 7 percent		/	/	/	/
Blood glucose (every three to six months)	Less than 154 mg/dL		/	/	/	/
Blood pressure (every office visit)	Less than 120/80 mm Hg		/	/	/	/
Weight (or BMI) (every office visit)	----------		/	/	/	/
LDL (once a year)	Less than 100 mg/dL		/	/	/	/
HDL (once a year)	Women: Above 50 mg/dL Men: Above 40 mg/dL		/	/	/	/
Serum creatinine (once a year)	GFR (glomerular filtration rate) above 60 mL/min		/	/	/	/
Urine albumin (once a year)	----------		/	/	/	/
Comprehensive foot exam (once a year)	----------		/	/	/	/
Dilated eye exam (once a year)	----------	----------	/	/	/	/
Dental exam (twice a year)	----------	----------	/	/	/	/
Flu shot (once a year)	----------	----------	/	/	/	/
Pneumonia vaccine (check with your doctor)	----------	----------	/	/	/	/
Hepatitis B vaccine (three shots over six months)	----------	----------	/	/	/	/

Smoking may increase your chances of having problems with diabetes and other health conditions. If you smoke and need help to quit, call The Hawaii Tobacco QuitLine at 1 (800) QUIT-NOW (784-8669) toll-free or go to hawaiiquitline.org.

The Hawaii State Department of Health's (DOH) Tobacco Quitline provides programs for members who want to quit smoking or using tobacco products on behalf of HMSA.

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