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Note: Masters Theses

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8a Have you consulted with this patient before?  1 Yes  2 No (ID __________)
b Are they male or female?  1 Male  2 Female
c How old are they? _________ years
d What is their ethnicity?  1 NZ European  2 Maori  3 Samoan  4 Cook Island Maori  5 Tongan  6 Niuean  7 Chinese  8 Indian  9 Other ________________
e What type of diabetes do they have?  1 Type 1  2 Type 2  3 Don’t know
f Where did you carry out this consultation?  1 A separate (or your own) room  2 A shared consulting room  3 In patients own home  4 Other ________________
g Was this a “Get checked” consultation?  1 Yes  2 No  3 N/A  Or other ‘special’ assessment’ __________
h How long did this consultation last: _________ minutes

9a. During this consultation did you ________________?  (read out each)
   1 Weigh the patient  1 Yes  2 No  if yes, what was their weight _____kg  or  BMI _____
   2 Take their blood pressure  1 Yes  2 No  if yes, what was their BP _________mmHg
   3 Check their feet  1 Yes  2 No  If yes, what did you check:  (not prompted)
      1 Pulses  2 Colour  3 Skin Integrity  4 Nails  5 Sensation  6 Microfilament test  7 Oedema  8 Other ______________________
   4 Assess their BGL’s (finger prick)  1 Yes  2 No
   5 Give wound care (i.e. change a dressing)  1 Yes  2 No
   6 Other (please specify) ______________________

  b Does this patient self monitor their BGL’s?  1 Yes  2 No  3 Don’t Know  
     If yes, did you discuss their BGL’s?  1 Yes  2 No

  c Did you give advice about foot protection?  1 Yes  2 No
     If yes, what advice did you give? ________________________________

10. Regarding test results
a How long ago did this patient have a blood test?  Date of last test: ____, ____, ____ (day, month, year)
   1 \leq 3 months  2 4 - 6 months  3 7 - 12 months  4 > 12 months  5 Don’t know
   If \leq 3 months did you discuss their blood test results at this consultation?  1 Yes  2 No
      If yes, which, results did you discuss?  (not prompted)
         1 HbA1c  1 Yes  2 No  if yes what was their HbA1c _________ %
         2 Lipid results  1 Yes  2 No  if yes what was their Total Cholesterol _________ mmol/L
         3 Serum creatinine  1 Yes  2 No  if yes what was their Serum Creatinine _________ mmol/L
         4 Other __________________________

b How long ago did this patient have a urine test for microalbuminuria?  
   1 \leq 3 months  2 4 - 6 months  3 7 - 12 months  4 > 12 months  5 Don’t know

  c How long ago did this patient have a retinal screen?  1 < 2 years  2 > 2 years  3 Don’t know
11. Regarding medications
   a. Do you know what medications this patient has been prescribed? 1 Yes 2 No
      - If yes, what medications have they been prescribed?
        1 Metformin 1 Yes 2 No
        2 Sulphonylurea 1 Yes 2 No
        3 Aspirin 1 Yes 2 No
        4 Warfain 1 Yes 2 No
        5 Beta blocker 1 Yes 2 No
        6 Ace Inhibitor 1 Yes 2 No
        7 Statin 1 Yes 2 No
        8 Insulin 1 Yes 2 No
        9 Glitazone 1 Yes 2 No
        10 Alpha-glucosidase Inhibitor 1 Yes 2 No
        11 Other ___________________________

   b. Does this patient routinely take their medications? 1 Yes 2 No 3 Don’t know

   c. Did you give advice about their medication? 1 Yes 2 No
      if yes please state ____________________________

12. Regarding education and health promotion
   a. Does this patient smoke? 1 Yes 2 No
      - If yes, do they want to stop? 1 Yes 2 No 3 Don’t know
      - If yes, did you suggest nicotine replacement therapy? 1 Yes 2 No
      - Did you advise of any community support services? 1 Yes 2 No
      if yes, state ______________

   b. Did you give advice about: diet, physical activity or other health issue? (read out)
      1 Diet 1 Yes 2 No
         if yes, what did you advise? ____________________________
      2 Physical Activity 1 Yes 2 No
         if yes, what did you advise? ____________________________
      3 Other (please specify) ____________________________

   c. Did you give out a “Green Prescription”? 1 Yes 2 No
      - if yes, state main activity ____________________________
      - if no, have you ever given a “Green Prescription” to this patient before? 1 Yes 2 No

13. Regarding follow up
   a. Does this patient make regular appointments at your practice / service? 1 Yes 2 No 3 N/A
      - If yes, when was their last appointment? _______, _______, _______ (day, month, year)
        1 ≤ 3 months  2 4 - 6 months  3 7 - 12 months  4 > 12 months  5 Don’t know
        - If no, was a follow-up appointment made? 1 Yes 2 No
        - if yes, what is the date for this appointment? _______, _______, _______ (day, month, year)

   b. Did you organize or advise any other appointments? 1 Yes 2 No
      - if yes please state the type of follow up appointment?
        1 G/P 2 Practice Nurse 3 DNS or DN educator 4 Diabetologist 5 Dietitian
        6 Podiatrist 7 Ophthalmologist 8 Other (please specify) ____________________________

   c. Is this patient able to telephone you directly? 1 Yes 2 No 3 Yes - via receptionist or clerk

   d. Do you plan to make any follow-up telephone calls? 1 Yes 2 No
      - if yes, what issues will you follow up? ____________________________

   e. Please estimate the time this follow-up will take ______ minutes or ______ minutes / week