**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 N Z European 2 Maori 3 Samoan 4 Cook Inland 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 <u>self</u> 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 <u>test results</u>**

a How long ago did this patient have a blood test? Date of last test: ____, ____, ____ (day, month, year)

1 ≤ 3 months 2 4 - 6 months 3 7 - 12 months 4 > 12 months 5 Don't know

- ***If ≤ 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 <u>microalbuminuria</u>?

1 ≤ 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 <u>medications</u>**

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 | Sulphonlyurea | 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 <u>education and health promotion</u>**

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: <u>diet</u>, <u>physical activity</u> or <u>other health issue</u>? ***(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 <u>follow up</u>**

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