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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 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 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 Warfarin                     | 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 | <b>if yes</b> , what did you advise? _____ |
| 2 Physical Activity            | 1 Yes | 2 No | <b>if yes</b> , 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