

Components of the initial assessment and care plan

Assessment

- Acute medical history
- Social, cultural and educational history/lifestyle review
- Complications history/symptoms
- Long-term/recent diabetes history
- Other medical history/systems review
- Family history of diabetes/cardiovascular disease
- Medication history/current medicines
- Vascular risk factors
- Smoking
- General examination
- Weight/BMI
- Foot/eye/vision examination
- Urine albumin excretion/urine protein/serum creatinine
- Psychological wellbeing
- Attitudes to medicine and self-care
- Immediate family and social relationships and availability of informal support

Care plan

- Sites and timescales of diabetes education, including nutritional advice
- Initial treatment modalities, including guidance on insulin injection and insulin regimens
- Means of self-monitoring and targets
- Symptoms, risk and treatment of hypoglycaemia
- Management of special situations such as driving
- Means and frequency of communication with the diabetes team
- Management of cardiovascular risk factors
- For women of childbearing potential, implications for pregnancy and family planning advice (see the NICE guideline on diabetes in pregnancy²)
- Frequency and content of follow-up consultations, including review of HbA_{1c} levels and experience of hypoglycaemia, and annual review