Care Plans: Diabetic Chart Form

Kathleen Jezewska SRN

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Diabetic Chart Form

All our patients had a Diabetic Chart Form. The Form was filled in at our Nursing Home.
The form was initially filled in by the senior nurse on duty at the time of admission. The form was filled in with information from the patient or with the help of the person currently caring for them; be that a carer, another Home or hospital. This is part of the care plan so that if a patient suffered or was at risk of diabetes the Home could plan how to care for them. The doctor, or district nurse could be involved in this process.
The information on this form could be checked against the Pre-Admission Assessment Form as a check on any deterioration in the condition of the patient as these forms may be filled in weeks or even months apart.
It is important to determine if the patient already has diabetes or is exhibiting signs of imminent diabetes. Medication or other conditions could increase the risk, so it is important to be aware.
This form is to detail the blood sugar of the patient in sufficient detail that so that a diagnosis can be made and the planning of the care process can begin. Notes about the medication, special treatments and diets, specialist equipment and so on can be included.

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