

DIABETES ACTION PLAN

Name: _____

Medical Provider's
Name: _____

Nurse's
Name: _____

Medical Social Worker's
Name: _____

Medical Provider's
Phone: _____

Nurse's
Phone: _____

Medical Social Worker's
Phone: _____

THINGS TO DO EVERYDAY FOR MY DIABETES:

1. Check my blood sugar (fill in chart below with your doctor)
2. Check my feet everyday for sores or redness
3. Wear shoes and socks that fit well
4. Take all of my medicine as prescribed, even when I feel well
5. Follow my meal plan
6. Get some exercise
7. Talk to my medical provider if I am having problems or have questions about my diabetes

TESTING MY BLOOD SUGAR:

I plan to test my blood sugar _____ times per day.

- | | |
|---|--|
| <input type="checkbox"/> Before breakfast | <input type="checkbox"/> _____ hours after breakfast |
| <input type="checkbox"/> Before lunch | <input type="checkbox"/> _____ hours after lunch |
| <input type="checkbox"/> Before dinner | <input type="checkbox"/> _____ hours after dinner |
| <input type="checkbox"/> Before bedtime | |



PLAN:

Discuss with my medical provider:

- ☐ Meal plan _____
- ☐ Activity/Exercise plan _____
- ☐ Medication Adjustment based on blood sugar results _____

Discuss with my medical provider:

- | | | | | |
|---|---|---|--------------------------------------|--|
| <input type="checkbox"/> Eye exam by eye doctor | <input type="checkbox"/> Pneumonia shot | <input type="checkbox"/> Annual Flu vaccine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Daily Foot Care |
| <input type="checkbox"/> ACE/ARB medication | <input type="checkbox"/> Annual foot exam by doctor | <input type="checkbox"/> Urine test for protein | <input type="checkbox"/> LDL Testing | |

Goals:

My weight is: _____	My goal is: _____	My A1C: _____	My goal is: _____
My blood pressure is: _____	My goal is: _____	My blood sugar is: _____	My goal is: _____
My LDL Cholesterol is: _____	My goal is: _____		

SIGNS OF HIGH BLOOD SUGAR:SUGAR:

- Feeling thirsty
- Urinating more frequently
- Feeling hungry
- Blurry or change in vision
- Feeling tired
- Feeling nauseated
- Feeling weak
- Rapid, shallow breathing
- Warm, dry or flushed skin
- Fruity breath odor

What Should I do? Ask your medical provider for instructions.

Check blood sugar and if over _____, call your medical provider for instructions.

SIGNS OF LOW BLOOD SUGAR:

- Feeling shaky or weak
- Feeling tired
- Feeling dizzy
- Headache
- Impulse to vomit
- Sweating
- Blurry vision
- Feeling confused
- Seizure
- Passing out

What Should I do? Ask your doctor for instructions.

Check blood sugar. If blood sugar is below 70, eat or drink something with 15 grams of carbohydrate (see list below). Check your blood sugar again in 15 minutes and if it is still below 70, eat or drink another snack with 15 grams of carbohydrate.

Good choices for treating low blood sugar. Choose one and make sure to always have that snack with you.

- Drink ½ cup of orange juice
- Chew and swallow 5-6 Lifesavers candy
- Chew and swallow 3 glucose tablets (find these at a pharmacy)
- Drink ½ cup of regular soda (Coke, Sprite, Pepsi)



TALK TO MY MEDICAL PROVIDER TODAY IF:

- | | |
|--|---|
| <input type="checkbox"/> My blood sugar is over _____ | <input type="checkbox"/> I have new speech problems |
| <input type="checkbox"/> My blood sugar is less than _____ | <input type="checkbox"/> I have new sores or redness on my feet |
| <input type="checkbox"/> I have chest pain or tightness | <input type="checkbox"/> I feel dizzy or confused |
| <input type="checkbox"/> I feel weak or have tingling on one side of my body | <input type="checkbox"/> I feel more thirsty |
| <input type="checkbox"/> I have new vision problems | <input type="checkbox"/> I need to urinate more than usual |