

Figure 2

Patient Report Card

My List of Laboratory Data and Other Tests

(front of card)

NAME _____

Laboratory & Other Tests	Date & Results	Date & Results	Date & Results	Date & Results
A_{1c} (At least every 3 months)				
Lipids Total Cholesterol Triglycerides HDL LDL (Annually and as indicated)				
FBS (Annually and as indicated)				
ALT/AST (Annually and as indicated)				
BUN/Cr (Annually and as indicated)				
Calculated GFR (Annually and as indicated)				
Electrolytes Na+ K+ (Annually and as indicated)				
TSH (As indicated)				
Hgb/Hct (Annually and as indicated)				
Urine albumin and microalbumin-creatinine ratio (Annually and as indicated)				
ECG (Initially and as indicated)				

My List of Immunizations, Other Exams and Measurements

(back of card)

Immunizations	Date	Date
1. Tetanus (Every 10 years)		
2. Influenza (Annually)		
3. Pneumococcal (At diagnosis; another if 65 or older and first dose given before 65)		
4. Hepatitis B (HBV) (If kidney status is compromised and GFR <60, or at high risk)		
5. PPD (Once; repeat if TB exposure)		
Other Exams	Date	Date
1. Eye Exam (Annually and as indicated)		
2. Dental Exam (Annually and as indicated)		
3. Foot Exam (Every visit)		
Measurements	Date	Date
1. Height		
2. Weight		
3. BMI		
4. Waist Circumference		
Clinic Name Provider Name Clinic Address Clinic Phone Number & Fax Number		