**SBRANA PSYCHIATRIC HOSPITAL**

**NURSING DEPARTMENT**

**DIABETES SCREENING TOOL**

**FILE NO……………………**

**NAME…………………………………………………… GENDER M/F………. AGE………**

**BMI………….. BP…………. FBS/RBS…………… DIAGNOSIS………………..**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **COMMENTS** |
| FAMILY HISTORY OF DIABETES |  |  |  |
| WEIGHT GAIN/LOSS |  |  |  |
| POLYUREA |  |  |  |
| POLYPHAGIA |  |  |  |
| POLYDIPSIA |  |  |  |
| ON ANTI PSYCHOTIC e.g. OLANZAPINE,CLOZAPINE AND QUTIAPINE |  |  |  |
| ANY RECURRENT FOOT ULCERS |  |  |  |
| LAST FBS CHECK |  |  |  |
| IMPAIRED VISION |  |  |  |
| ANY HISTORY OF HYPERTENSION |  |  |  |
| URINALYSIS |  |  |  |
|  |  |  |  |

**Key note:** all patients with a score of 25% and above should be referred to the doctor

**Recommendations**

**……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………...**

Next screening date:…………………..

Signature of the assessor……………………….

Compiled by:PRN`S M KEFHILWE AND B MONYIKA

PRESENTED BY:CRN NGWENYA

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | NAMES | DESIGNATION | SIGNATURE | DATE |
| APPROVED BY |  |  |  |  |
| AUTHORIZED BY |  |  |  |  |