APPENDIX 2 - ESSENTIAL NCD HEALTH INTERVENTION PROJECT – DIABETES INITIAL ASSESSMENT FORM

Patient number  d d d d  Village __________________________
Name __________________________
Sex □ Male  □ Female
Age (years)  d d d  DOB (dd/mm/yy)  d d d / d d d / d d d  Family Head

INITIAL ASSESSMENT

1. Date  d d d / d d d / d d d
2. Fasting Capillary glucose (mmol.l⁻¹)  d d . d (Copy from screening form if done)
3. Other diagnosed conditions  Year of diagnosis  Year of diagnosis
   Hypertension  d d d d  Renal disease  d d d d
   Ischaemic heart disease  d d d d  Stroke  d d d d
   Other __________________________  d d d d
   Pregnant?  Yes  Y  No  Y

4. Complaints
   Nocturia (frequency)  / night  5. Legs and Feet
   Polyuria  / Weeks  Loss of sensation?  Yes  □  No  □  Yes  □  No  □
   Polydipsia  / Weeks  At least one foot pulse present?  Yes  □  No  □  Yes  □  No  □
   Weight loss despite good appetite  / Weeks  Evidence of infection?(S)
   Frequent infections  / Weeks
   Disturbed eye sight  / Weeks
   Impotence  / Weeks
   Numbness, burning sensation in legs/hands  / Weeks

6. Urine tests
   Protein
   Ketones (S)
   Urine tests
   0  +  ++  +++

7. Current medication
8. Impression

9. CONCLUSION

10. ACTION TO BE TAKEN

Pregnant  ⇐  Refer to hospital
Severe symptoms (S)  ⇐  Refer to hospital
Newly diagnosed patient, no complications  ⇐  Start on non-pharmacological methods. Next appointment in 1 month)
Patient already diagnosed and:
   Using ENHIP drugs  ⇐  Continue current treatment
   Using non-ENHIP drugs and:
      Controlled  ⇐  Continue with current therapy. Next appointment in 3 months.
      Not controlled  ⇐  Switch to ENHIP drugs at starting dose. Next appointment in 1 month.

11. HEALTH EDUCATION

   Dietary advice given?  Yes  □  No  □  Smoking advice given?  Yes  □  No  □
   Weight loss advice given  Yes  □  No  □  Alcohol advice given?  Yes  □  No  □
   Exercise advice given?  Yes  □  No  □  Foot care advice given  Yes  □  No  □

12. DRUGS PRESCRIBED

   Mg  Times/day

   Glibenclamide  d d d d
   Metformin  d d d d
   Other  d d d d

13. Date of next appointment
   (one or 3 months)
## Appendix 3 - Essential NCD Health Intervention Project – Diabetes Follow-up Form

### Patient Information
- **Patient number**: dddd
- **Village**: 
- **Name**: 
- **Sex**: Male ☐ Female ☐
- **Age (years)**: 
- **DOB (dd/mm/yy)**: 
- **Family Head**: 

### Assessment

<table>
<thead>
<tr>
<th>Follow-up #</th>
<th>Follow-up #</th>
<th>Follow-up #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual check done this year?</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Pregnant?</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Polyuria (weeks)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Polydipsia (weeks)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Infections</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Weight (Kg)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pulse rate (beats/min)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Fasting blood glucose (mmol/l)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Blood pressure (mmHg)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Complaints

- **Current medication**: 
- **Impression**: 

### Conclusion

**ACTION TO BE TAKEN**

<table>
<thead>
<tr>
<th># vvv</th>
<th># vvv</th>
<th># vvv</th>
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</thead>
<tbody>
<tr>
<td>Bp &gt; 140/90 and not already on blood pressure treatment ⇐ Repeat measurement, following hypertension guideline and, if confirmed, treat as in guideline.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Patient is pregnant, has severe symptoms, or infections ⇐ Refer to hospital</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Patient is on highest level of drugs and still not controlled ⇐ Refer to hospital</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

If no acute complications (i.e. none of the above):

- **Patient is still on 3 month trial of non-pharmacological methods (step 1)** ⇐ Continue with non-pharmacological methods until 3 months have been completed | Y | Y | Y |
- **Patient controlled on current regime** ⇐ Continue the current regime. Next appointment in 3 months | Y | Y | Y |

**Patient is not controlled on current regime, and:**

- **On maximum dose of first drug** ⇐ Add second hypoglycaemic drug | Y | Y | Y |
- **Not yet on maximum dose of first drug** ⇐ Increase dose of hypoglycaemic drug | Y | Y | Y |
- **3 month trial of non-pharmacological methods has been tried** ⇐ Start on oral hypoglycaemic drug | Y | Y | Y |

### Non-pharmacological Methods

- **Dietary advice given?**: Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
- **Weight loss advice given**: Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
- **Exercise advice given**: Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
- **Foot care advice given**: Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
- **Smoking advice given?**: Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
- **Alcohol advice given?**: Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐

### Drugs Prescribed

- **Glibenclamide**: mg | Times/day
- **Metformin**: mg | Times/day

### Date of Next Appointment

One or 3 months from today
**APPENDIX 4 - ESSENTIAL NCD HEALTH INTERVENTION PROJECT – DIABETES ANNUAL EVALUATION FORM**

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Village</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age (years)</th>
<th>DOB (dd/mm/yy)</th>
<th>Family Head</th>
</tr>
</thead>
<tbody>
<tr>
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### ANNUAL ASSESSMENT (do this once a year)

1. Date

2. How many hours of moderate or intense physical activity do you take in a week?  
   (e.g. brisk walking, cycling, running, heavy labour - include work and leisure)  
   - [ ] <0.5  
   - [ ] 0.5-1.5  
   - [ ] >1.5-5  
   - [ ] >5

3. Do you add salt to prepared food?  
   - [ ] Yes  
   - [ ] No

4. Do you drink (alcoholic drinks)?
   - [ ] Yes  
   - [ ] No

   **How many bottles or shots of...**
   - [ ] bottled beer  
   - [ ] shots of spirits  
   - [ ] Glasses of wine  
   - [ ] traditional alcoholic drinks

   **How often?**
   - [ ] manufactured cigarettes  
   - [ ] Home-made cigarettes  
   - [ ] pipe

5. Do you smoke?
   - [ ] Yes  
   - [ ] No

   **How often?**
   - [ ] manufactured cigarettes  
   - [ ] Home-made cigarettes  
   - [ ] pipe

### 6. Complaints (in addition to those on follow-up form)

- Nocturia (frequency)
- Weight loss despite good appetite
- Frequent infections
- Disturbed eye sight
- Numbness, burning
- Sensation in legs/hands
- Impotence
- Right
- Left

### 7. Legs and Feet

- Loss of sensation
- At least one foot pulse present
- Evidence of infection
- Protein
- Ketones

### ANNUAL LIFE-STYLE ASSESSMENT (do this once a year)

1. Date

2. How many hours of moderate or intense physical activity do you take in a week?  
   (e.g. brisk walking, cycling, running, heavy labour - include work and leisure)  
   - [ ] <0.5  
   - [ ] 0.5-1.5  
   - [ ] >1.5-5  
   - [ ] >5

3. Do you add salt to prepared food?  
   - [ ] Yes  
   - [ ] No

4. Do you drink (alcoholic drinks)?
   - [ ] Yes  
   - [ ] No

   **How many bottles or shots of...**
   - [ ] bottled beer  
   - [ ] shots of spirits  
   - [ ] Glasses of wine  
   - [ ] traditional alcoholic drinks

   **How often?**
   - [ ] manufactured cigarettes  
   - [ ] Home-made cigarettes  
   - [ ] pipe

5. Do you smoke?
   - [ ] Yes  
   - [ ] No

   **How often?**
   - [ ] manufactured cigarettes  
   - [ ] Home-made cigarettes  
   - [ ] pipe

6. Complaints (in addition to those on follow-up form)

- Nocturia (frequency)
- Weight loss despite good appetite
- Frequent infections
- Disturbed eye sight
- Numbness, burning
- Sensation in legs/hands
- Impotence
- Right
- Left

8. Urine tests

   **Protein**
   - [ ] +  
   - [ ] ++  
   - [ ] +++