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

Patient number ☐☐☐☐ Village _____

Name _____

Sex Male ☐ Female ☐

Age (years) ☐☐☐ DOB (dd/mm/yy) ☐☐/☐☐/☐☐ Family Head

INITIAL ASSESSMENT

1. Date ☐☐/☐☐/☐☐

2. Fasting Capillary glucose (mmol.l^{-1}) ☐☐.☐ (Copy from screening form if done)

3. Other diagnosed conditions

	Year of diagnosis		Year of diagnosis
Hypertension	☐☐☐☐	Renal disease	☐☐☐☐
Ischaemic heart disease	☐☐☐☐	Stroke	☐☐☐☐
Other _____	☐☐☐☐		

Pregnant? Yes Y No Y

4. Complaints

Nocturia (frequency)	☐☐	/night
Polyuria	☐☐	Weeks
Polydipsia	☐☐	Weeks
Weight loss despite good appetite	☐☐	Weeks
Frequent infections	☐☐	Weeks
Disturbed eye sight	☐☐	Weeks
Impotence	☐☐	Weeks
Numbness, burning sensation in legs/hands	☐☐	Weeks

5. Legs and Feet

	Right		Left	
Loss of sensation?	Yes ☐	No ☐	Yes ☐	No ☐
At least one foot pulse present?	Yes ☐	No ☐	Yes ☐	No ☐
Evidence of infection?(S)	Yes ☐	No ☐	Yes ☐	No ☐

6. Urine tests

	0	+	++	+++
Protein	☐	☐	☐	☐
Ketones (S)	☐	☐	☐	☐

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 1month.	☐

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	13. Date of next appointment
Glibenclamide	☐☐☐	☐	
Metformin	☐☐☐	☐	☐☐/☐☐/☐☐ (one or 3 months)
Other	☐☐☐	☐	

APPENDIX 3 - ESSENTIAL NCD HEALTH INTERVENTION PROJECT – DIABETES FOLLOW-UP FORM

Patient number ⎵⎵⎵⎵ Village _____

Name _____

Sex Male □ Female □

Age (years) ⎵⎵⎵ DOB (dd/mm/yy) ⎵⎵/⎵⎵/⎵⎵ Family Head

ASSESSMENT		Follow-up # vvv	Follow-up # vvv	Follow-up # vvv
	Date	⎵⎵/⎵⎵/⎵⎵	⎵⎵/⎵⎵/⎵⎵	⎵⎵/⎵⎵/⎵⎵
	Annual check done this year?	Yes Y No Y	Yes Y No Y	Yes Y No Y
	Pregnant?	Yes Y No Y	Yes Y No Y	Yes Y No Y
COMPLAINTS	Polyuria (weeks)	⎵⎵	⎵⎵	⎵⎵
	Polydipsia (weeks)	⎵⎵	⎵⎵	⎵⎵
	Infections	Yes Y No Y	Yes Y No Y	Yes Y No Y
	Weight (Kg)	⎵⎵⎵	⎵⎵⎵	⎵⎵⎵
	Pulse rate (beats/min)	⎵⎵⎵/min	⎵⎵⎵/min	⎵⎵⎵/min
	Fasting blood glucose (mmol/l)	⎵⎵.⎵	⎵⎵.⎵	⎵⎵.⎵
	Blood pressure (mmHg)	⎵⎵⎵/⎵⎵⎵	⎵⎵⎵/⎵⎵⎵	⎵⎵⎵/⎵⎵⎵
	Current medication			
	Impression			

CONCLUSION	ACTION TO BE TAKEN	# vvv	# vvv	# vvv
Bp > 140/90 and not already on blood pressure treatment	⇐ Repeat measurement, following hypertension guideline and, if confirmed, treat as in guideline.	Y	Y	Y
Patient is pregnant, has severe symptoms, or infections	⇐ Refer to hospital	Y	Y	Y
Patient is on highest level of drugs and still not controlled	⇐ Refer to hospital	Y	Y	Y
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	1# vvv	# vvv	# vvv
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	mg	Times/day	mg	Times/day	mg	Times/day
Glibenclamide	⎵⎵⎵	⎵	⎵⎵⎵	⎵	⎵⎵⎵	⎵
Metformin	⎵⎵⎵	⎵	⎵⎵⎵	⎵	⎵⎵⎵	⎵

DATE OF NEXT APPOINTMENT	# vvv	# vvv	# vvv
One or 3 months from today	⎵⎵/⎵⎵/⎵⎵	⎵⎵/⎵⎵/⎵⎵	⎵⎵/⎵⎵/⎵⎵

APPENDIX 4 - ESSENTIAL NCD HEALTH INTERVENTION PROJECT – DIABETES ANNUAL EVALUATION FORM

Patient number ☐☐☐☐ Village _____

Name _____

Sex Male ☐ Female ☐

Age (years) ☐☐☐ DOB (dd/mm/yy) ☐☐/☐☐/☐☐ Family Head

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...	Day	week	month	Year
bottled beer	☐☐	☐☐	☐☐	☐☐
shots of spirits	☐☐	☐☐	☐☐	☐☐
Glasses of wine	☐☐	☐☐	☐☐	☐☐
traditional alcoholic drinks	☐☐	☐☐	☐☐	☐☐

5. Do you smoke? Yes ☐ No ☐

How often?	Per wk	<10/d	10-20/d	>20/d
manufactured cigarettes	☐☐	☐	☐	☐
Home-made cigarettes	☐☐	☐	☐	☐
pipe	☐☐	☐	☐	☐

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

Nocturia (frequency)	☐☐	/night
Weight loss despite good appetite	☐☐	Weeks
Frequent infections	☐☐	Weeks
Disturbed eye sight	☐☐	Weeks
Numbness, burning	☐☐	Weeks
Sensation in legs/hands	☐☐	Weeks
Impotence	☐☐	Weeks

7. Legs and Feet

	Right		Left	
Loss of sensation?	Yes ☐	No ☐	Yes ☐	No ☐
At least one foot pulse present?	Yes ☐	No ☐	Yes ☐	No ☐
Evidence of infection?	Yes ☐	No ☐	Yes ☐	No ☐

8. Urine tests

	0	+	++	+++
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...	Day	week	month	Year
bottled beer	☐☐	☐☐	☐☐	☐☐
shots of spirits	☐☐	☐☐	☐☐	☐☐
Glasses of wine	☐☐	☐☐	☐☐	☐☐
traditional alcoholic drinks	☐☐	☐☐	☐☐	☐☐

5. Do you smoke? Yes ☐ No ☐

How often?	Per wk	<10/d	10-20/d	>20/d
manufactured cigarettes	☐☐	☐	☐	☐
Home-made cigarettes	☐☐	☐	☐	☐
pipe	☐☐	☐	☐	☐

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

Nocturia (frequency)	☐☐	/night
Weight loss despite good appetite	☐☐	Weeks
Frequent infections	☐☐	Weeks
Disturbed eye sight	☐☐	Weeks
Numbness, burning	☐☐	Weeks
Sensation in legs/hands	☐☐	Weeks
Impotence	☐☐	Weeks

7. Legs and Feet

	Right		Left	
Loss of sensation?	Yes ☐	No ☐	Yes ☐	No ☐
At least one foot pulse present?	Yes ☐	No ☐	Yes ☐	No ☐
Evidence of infection?	Yes ☐	No ☐	Yes ☐	No ☐

8. Urine tests

	0	+	++	+++
Protein	☐	☐	☐	☐
Ketones	☐	☐	☐	☐