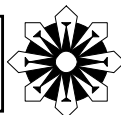




57562

# ANDA-AQSM 2014 Australian National Diabetes Audit - Australian Quality Self Management Audit



## Section 1. Patient Demographics

Medical Record No.           Centre ID    Site Staff Identifier

1.1 Date of Birth   /   /      1.2 Sex  Male  Female **if FEMALE** → 1.2.1 Currently pregnant  No  Yes

1.3 Date of Visit   /   /      1.4 Initial Visit  No  Yes 1.5 Aboriginal/Torres Strait Islander  No  Yes

1.6 Interpreter required  No  Yes 1.7 DVA Patient  No  Yes 1.8 NDSS Member  No  Yes

1.9 Country of birth

## Section 2. Diabetes Type & Management & Lifestyle Issues

2.1 Year of Diagnosis     2.2 Type of Diabetes  Type 1  Type 2  GDM  Don't Know  Other

2.3 Management Method  Diet Only  Insulin **if INSULIN** → 2.3.1 How long ago was Insulin started  <1yr  1-5yrs  >5yrs 2.4 Physical Activity Sufficiency  Sufficient  Insufficient  Sedentary

Tablets  Insulin+Tablets  Injectables  Insulin+Tablets+Injectables  Injectables+Tablets  Nil

2.5 Have you had a flu vaccination in the last 12 months?  No  Yes 2.6 Have you had a pneumococcal vaccination in the last 12 months?  No  Yes

2.7 Smoking Status  Current Smoker **if CURRENT** → 2.7.1 Have you tried to stop smoking?  No  Yes  Past Smoker **if PAST** → 2.7.2 Which of the following methods did you use:  Never Smoked

	No	Yes	No	Yes
Just Stopped - no intervention	<input type="checkbox"/>	<input type="checkbox"/>	Hypnosis	<input type="checkbox"/>
Medication	<input type="checkbox"/>	<input type="checkbox"/>	Acupuncture	<input type="checkbox"/>
Nicotine replacement	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>

2.8 Glycated Hb Result   .  % AND    mmol/mol

## Section 3. Medication Use

	No	Yes
3.1 Do you ever forget to take your medications?	<input type="checkbox"/>	<input type="checkbox"/>
3.2 Do you usually take all your medications?	<input type="checkbox"/>	<input type="checkbox"/>
3.3 Do you sometimes stop taking your medications when you feel better?	<input type="checkbox"/>	<input type="checkbox"/>
3.4 Do you sometimes stop taking your medications when you feel worse?	<input type="checkbox"/>	<input type="checkbox"/>
3.5 Are you using a complementary therapy or dietary supplement or OTC Rx?	<input type="checkbox"/>	<input type="checkbox"/>
3.5.1 Have you told your doctor or educator about using complementary, dietary supplement or OTC Rx?	<input type="checkbox"/>	<input type="checkbox"/>

**if YES** → 3.1.1 How many times per week

**if YES Answer 3.5.1**

## Section 4. Health Professional Attendances

Has the patient attended any of the following in the last 12 months?

	No	Yes	No	Yes
4.1 Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>	4.6 Diabetes Specialist	<input type="checkbox"/>
4.2 Diabetes Educator	<input type="checkbox"/>	<input type="checkbox"/>	4.7 Ophthalmologist	<input type="checkbox"/>
4.3 Dietitian	<input type="checkbox"/>	<input type="checkbox"/>	4.8 Optometrist	<input type="checkbox"/>
4.4 Psychologist	<input type="checkbox"/>	<input type="checkbox"/>	4.9 Dentist	<input type="checkbox"/>
4.5 Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	4.10 Exercise Physiologist	<input type="checkbox"/>

## Section 5. Patient Self Care Practices

	No	Yes
5.1 Do you have difficulties following your prescribed diet?	<input type="checkbox"/>	<input type="checkbox"/>
<b>if YES</b> → Do the following apply		
5.1.1 I don't have enough time to prepare healthy meals	<input type="checkbox"/>	<input type="checkbox"/>
5.1.2 It costs too much to eat well	<input type="checkbox"/>	<input type="checkbox"/>
5.1.3 I don't know what foods are best to eat	<input type="checkbox"/>	<input type="checkbox"/>
5.1.4 I eat out a lot and find it hard to eat well	<input type="checkbox"/>	<input type="checkbox"/>
5.1.5 If Type1 - it is too hard to count carbs/weigh food	<input type="checkbox"/>	<input type="checkbox"/>

5.2 Do you check your blood glucose level as often as recommended?  No  Yes  Unsure of recommended testing

5.3 If you are on injectables or insulin, do you rotate your injection site?  No  Yes

## Section 6A. BCD

Over the last couple of weeks has the patient been:

	No	Yes
6A.1 Having restless or disturbed nights	<input type="checkbox"/>	<input type="checkbox"/>
6A.2 Feeling unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
6A.3 Feeling unable to overcome difficulties	<input type="checkbox"/>	<input type="checkbox"/>
6A.4 Dissatisfied with their way of doing things	<input type="checkbox"/>	<input type="checkbox"/>

## Section 6B. Treatment

	No	Yes
6B.1 Is the patient taking antidepressants	<input type="checkbox"/>	<input type="checkbox"/>
6B.2 Psych. treatment/counselling - past	<input type="checkbox"/>	<input type="checkbox"/>
6B.3 Psych. treatment/counselling - now	<input type="checkbox"/>	<input type="checkbox"/>

## Section 7. Quality of Life Assessment

### Part A: Self-assessment of health status

7.1 Own health state rating (0-100)

7.2 Screening Scale Q1

7.3 Screening Scale Q2

**if Q1 or Q2 is ≥ 3, complete Part B**

### Part B: Diabetes Distress Scale 17

7.4 DDS 17 Questionnaire done  No  Yes **if YES** → complete 7.4.1 - 7.4.5 below

7.4.1 Total DDS 17 Score  .

7.4.2 Emotional Burden (A)  .

7.4.3 Physician-related distress (B)  .

7.4.4 Regimen-related distress (C)  .

7.4.5 Interpersonal distress (D)  .