# Hyperglycemia Nursing Care Plan

## PATIENT INFORMATION

**Full Name:** _____ **Date of Birth:** _____ dd / mm / yyyy

**Gender:** _____ **Patient ID:** _____

**Contact Number:** _____ **Email Address:** _____

**Diabetes Type**

- [ ] Type 1 diabetes present
- [ ] Type 2 diabetes present

Evaluation:Blood Glucose DeterminationThe patient has developed Type 2 diabetes if:A fasting plasma glucose level of 126 mg/dL or higherA 2-hour plasma glucose level of 200 mg/dL or higher during a 75-g oral glucose tolerance test (OGTT)Random plasma glucose of 200 mg/dL or higher in the presence of symptoms of hyperglycemia.A hemoglobin A1c level of 6.5% or higher

**Blood tests completed**

**Urine tests completed**

Indicate symptoms of hyperglycemia:

**Symptoms of hyperglycemia**

- [ ] Increased thirst
- [ ] Frequent urination
- [ ] Increased hunger
- [ ] Headaches
- [ ] Fatigue
- [ ] Blurry vision

AssessmentDiagnosisInterventionRationaleEvaluation

Outline services ensuring access to medication, regular care, community support and education:

**Service / Education**

**Provider and referral date**

## Physician's Notes and Recommendations

Physician's Signature

Date: _____ dd / mm / yyyy