USDA Forest Service Fire Medical Qualifications Program

Diabetes Mellitus (FAX 866-338-6630)

FOR MEDICAL PROVIDER USE ONLY

Employee Name and Date of Birth: ____

Home Unit/Forest: ____

(Medical provider complete as applicable. If questions, call Jennifer Symonds, D.O., 208-387-5978)

Medication list:____

____

____

____

____

Is the individual's diabetes currently static and stable with good compliance of ongoing care and treatment?   YES ____   NO ____

Please supply the last 3 or last year's worth of hemoglobin A1c's (with month/year), whichever covers a longer time period:____

____

How often is the individual to test their blood glucose? ________________________________

Do they have a Continuous Glucose Monitor? YES ____   No ____

How often is the individual to be seen in the office? ___________________________________

Has the individual been instructed on a back-up plan if they have an insulin pump?

NA ____ Yes ____ NO ____

What is the frequency of severe hypoglycemic episodes? And when was the last one? (severe episode defined as one that requires the assistance of others, or results in loss of consciousness, seizure, or coma)

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Does the individual have any diabetic end organ damage?

Renal (diabetic nephropathy, proteinuria, nephrotic syndrome, etc.)? YES ____ NO ____

If yes, supply diagnosis and whether the condition is stable and compatible with light, moderate or arduous work, as well as extreme heat: ____________________________________

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Cardiovascular (CAD, HTN, TIA, stroke, peripheral vascular disease, etc.)? YES ____ NO ____

If yes, supply diagnosis and whether the condition is stable and compatible with light, moderate or arduous work, as well as extreme heat: ____________________________________

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Neurologic (gastrointestinal or genitourinary neuropathy, peripheral neuropathy, etc.)?

YES ____ NO ____

If yes, supply diagnosis, location and type of involvement, and whether the condition is stable and compatible with light, moderate or arduous work, as well as extreme heat (including walking on hot ground):____

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Lower limbs (foot ulcers, amputated toes, infection, gangrene, etc.)? YES ____ NO ____

If yes, supply diagnosis and whether the condition is stable and compatible with light, moderate or arduous work, as well as extreme heat (including walking on hot ground): _______

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Other: (explain) ____

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____

Date of last comprehensive eye exam: ___________________________

Does the individual have any loss of field of vision, i.e. macular degeneration, etc.? YES ____ NO ____

Does the individual have any restrictions on their activity in regard to light, moderate, or arduous work, in extreme heat, in a wilderness environment with definitive care greater than an hour away? (If they are in an arduous duty position, please review the Essential Functions and Work Conditions of a Wildland Firefighter) YES ____ NO ____

If yes, please specify:

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Medical Provider Name: ____MD/DO/NP/PA/____

Address: ____

____

Phone #:____

Fax #:____