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 your HgA1c's for the past year/a screenshot of your CGM last 90 days' time in range/your medical provider's documentation of the percent time in range of your CGM and what the range is:_____

_____

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.)? NO ____ YES ____ If yes, supply diagnosis and whether the condition is stable and compatible with light, moderate or arduous work, as well as extreme heat:_____

_____

_____

Cardiovascular (CAD, HTN, TIA, stroke, peripheral vascular disease, etc.)? NO ____ YES ____ If yes, supply diagnosis and whether the condition is stable and compatible with light, moderate or arduous work, as well as extreme heat: _____

_____

_____

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

NO ____ YES ____ 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):_____

_____

_____

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

_____

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) NO ____ YES ____ If yes, please specify:

_____

_____

_____

_____

_____

_____

_____

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

Address: _____

_____

Phone #:_____

Fax #:_____