APPENDIX B: PHYSICIAN EVALUATION FORM FOR LEO WITH DIABETES

I. INTRODUCTION

The educated and motivated law enforcement officer (LEO) or applicant with well-managed diabetes mellitus can be capable of safe and effective job performance. An individualized assessment of the LEO’s or applicant’s diabetes should be performed including an assessment of the following:

- History of Diabetes and its Treatment
- Risk for Impairing Events (Symptomatic and Severe Hypoglycemia, Hypoglycemia Unawareness, Symptomatic Hyperglycemia, and Diabetic Ketoacidosis)
- Presence of Diabetic Complications

Risk of hypoglycemia remains the major concern in regard to those with diabetes being or becoming LEOs. This risk occurs primarily in those taking insulin, particularly those with type 1 diabetes, although it may also occur in those with type 2 diabetes who take insulin and/or sulfonylureas and other secretagogues.

Law enforcement entails a unique set of conditions that need to be considered in regard to those with diabetes and the risks of either hypo or hyperglycemia. These may include (depending upon the duties of the particular LEO position):

- unpredictable meal schedules;
- brief periods of maximal physical exertion;
- driving a vehicle, including high-speed pursuit driving;
- surveillance requiring sustained attention for prolonged periods of time;
- rapid decision making regarding the use of force, including deadly force;
- rapid analysis of complex visual stimuli to differentiate weapons from other objects; and
- control of one’s emotions under stress.

II. ASSESSMENT FORM*

1. LEO has been under the care of an endocrinologist or other treating physician knowledgeable about diabetes management. Outpatient and in-patient medical record(s) of the last three years or since date of diagnosis (whichever is shorter) should be reviewed by the treating physician and provided to the police physician.

   My credentials as a physician knowledgeable about diabetes management are as follows (or attach CV):

   ______________________________________________________________________________________
   ______________________________________________________________________________________

   This person has: □ type 1 diabetes □ type 2 diabetes

   Date of diagnosis: ____ ____ ____

   Please attach inpatient and outpatient records for the most recent 3 years or since onset of diabetes (whichever is shorter)

   *Times cited for durations of stable treatment regimen or stability of management are in reference to the date of current evaluation. Date sought is when patient first began current insulin regimen (pump or injection) using current types of insulin (long acting, intermediate acting, short or rapid acting).
Please complete the rest of this form if the information is not contained in the medical records that you are providing.

2. **If type 1 diabetes, please complete:**
   If type 1 diabetes, patient must be on a basal/bolus regimen or an insulin pump using analogue insulins for the six (6) months prior to evaluation.
   - [ ] Current insulin regimen: ____________________________
   - Insulin pump brand and model: ____________________________
   - Pump settings:
     - Start Time
     - Basal Rate
     - Start Time
     - Basal Rate
   - Usual bolus doses:
     - Breakfast ____________________________
     - Lunch ____________________________
     - Supper ____________________________
     - Other ____________________________
   - Correction factor ____________________________
   - Multiple dose insulin (specify regimen):
     - Basal: ____________________________
     - Bolus: ____________________________
   - Starting date on current regimen: _____/_____/_______

3. **If type 2 diabetes, please complete:**
   If type 2 diabetes on insulin, patient must be on a stable medication regimen for the three (3) months prior to evaluation. If not on insulin, patient must be on a stable medication regimen for the month prior to evaluation.
   - Current medication regimen (name, dosage, and frequency):
     - Non-insulin agents ____________________________
     - Insulin ____________________________
     - Non-insulin agents ____________________________
     - Insulin ____________________________
     - Non-insulin agents ____________________________
     - Insulin ____________________________
     - Non-insulin agents ____________________________
     - Insulin ____________________________
   - Starting date on current regimen: _____/_____/_______

4. **Glucose Log**
   Patient must have documentation of ongoing self-monitoring of blood glucose. This must be done with a glucose meter that stores every reading, records date and time of reading and from which data can be downloaded. The glucose log must be available covering one month if on insulin or on a sulfonylurea, or 2 weeks (daily fasting glucose) if on other agents or if diet-controlled.
The individual has been asked to test glucose _______ times a day, and

☑ is adhering to my recommended schedule for testing.
☑ is not adhering to my recommended schedule for testing.

Glucose logs:
☒ are attached for review
☒ are not attached for review (please explain): ______________________________________________________
________________________________________________________________________________________

Explanation for glucose values <70 mg/dl in the glucose log (cause of hypoglycemia, symptoms, corrective action(s), work/non-work activity): ______________________________________________________
________________________________________________________________________________________

Documentation of glucose testing after glucose values <60 mg/dl in the glucose log with time stamp for each value. Glucose values <60 mg/dl must be repeated initially within 15 minutes and repeated until glucose of 90 mg/dl or greater is reached. ______________________________________________________
________________________________________________________________________________________

5. Diabetes Education
Patient must be educated in diabetes and its management and thoroughly informed of and understands the procedures that must be followed to monitor and manage his/her diabetes and what procedures should be followed if complications arise.

The individual has completed the following diabetes education (include year of completion):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

6. Insulin Pump Use
If an insulin pump user, documentation provided for the following:
☒ proper understanding and education in the use of the insulin pump
☒ start date for the use of the pump
☒ history of insulin site infections
☒ history of pump cessation and pump malfunction
☒ backup plan for pump malfunction including use of injectable insulin
☒ frequency of infusion set changes

The individual has completed the following education in the use of a continuous insulin infusion pump (indicate year of completion):
________________________________________________________________________________________
________________________________________________________________________________________

The individual routinely carries appropriate supplies to compensate for pump malfunction, including syringes and insulin vials or insulin pens.
☒ Yes
☒ No – please explain: ______________________________________________________
________________________________________________________________________________________
Has the individual had any of the following insulin infusion issues over the past 12 months?

- Pump failure
- Insulin infusion set blockage
- Infusion site problems, including infection
- Insulin stability issues
- User error
- No insulin infusion issues in past 12 months

If insulin infusion issues have occurred in past 12 months, please describe and provide date(s):
_________________________________________________________________________________________
_________________________________________________________________________________________

7. **Continuous Glucose Monitor**

Has this individual used a continuous glucose monitor?

- No
- Yes. If yes:
  - Dates used: __________________________________________________________
  - Why used: ___________________________________________________________
  - Frequency of use: ___________________________________________________

8. **Hemoglobin A1C**

Patient must have a hemoglobin A1C measured at least four times a year (intervals of 2-3 months) over the last 12 months prior to evaluation if diagnosis has been present over a year. Provide A1C values and dates below:

<table>
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<tr>
<th>Date</th>
<th>HbA1C</th>
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9. **Impairing Events**

a. **Severe Hypoglycemia**

Has individual had episode of severe hypoglycemia (defined as an event requiring assistance of another person to actively administer carbohydrates, glucagon, or take other corrective action) in the past 3 years?

- Yes
- No

If the individual has had such episode(s), please describe episodes and provide dates of episodes:
_________________________________________________________________________________________
_________________________________________________________________________________________

b. **Diabetic Ketoacidosis**

Has individual had episode of diabetic ketoacidosis in the past 3 years?

- Yes
- No

If the individual has had such episode(s), please describe episodes and provide dates of episodes:
_________________________________________________________________________________________
_________________________________________________________________________________________

c. **Hyperosmolar Hyperglycemic State**

Has individual had episode of hyperosmolar hyperglycemic state in the past 3 years?

- Yes
- No

If the individual has had such episode(s), please describe episodes and provide dates of episodes:
_________________________________________________________________________________________
_________________________________________________________________________________________
10. **Eye Exam**

Patient must have a complete eye exam by a qualified ophthalmologist or optometrist, including a dilated retinal exam, documenting the presence or absence of retinopathy/macular edema and the degree of retinopathy and/or macular edema if present (using the International Classification of Diabetic Retinopathy and Diabetic Macular Edema).

Date of eye exam: _______________________________________________________________________

Eye exam indicates the presence of the following conditions:

- ☐ Proliferative diabetic retinopathy
- ☐ Severe non-proliferative diabetic retinopathy
- ☐ Moderate/Mild diabetic retinopathy *(circle one)*
- ☐ Clinically significant macular edema
- ☐ Moderate/Mild macular edema *(circle one)*
- ☐ None of the above

Copy of ophthalmology or optometry report is attached:

- ☐ Yes  ☐ No – please explain: ________________________________________________________________

Copy of automated visual perimetry field test (Humphrey or equivalent) is attached:

- ☐ Yes  ☐ No – please explain: ________________________________________________________________

Did the ophthalmologist or optometrist recommend activity restrictions (i.e., no contact sports, no strenuous physical activity) based on the results of the eye exam?

- ☐ Yes  ☐ No – please explain: ________________________________________________________________

11. **Neurologic Exam**

Patient must have normal vibratory testing with 128 Hz tuning fork, normal testing with 10 gram Semmes-Weinstein monofilament and normal orthostatic blood pressure (measurement of blood pressure sitting and within 3 minutes of standing) and pulse testing.

Vibration sensation: _____________________

Monofilament: _________________________

BP supine: ____________________________  Pulse supine: _______________

BP standing: ____________________________ Pulse standing: _____________

Neurologic exam indicates the presence of the following conditions:

- ☐ Physical activity or performance is limited due to pain, weakness or numbness
- ☐ Ataxia
- ☐ Reduced balance during observation of gait
- ☐ Reduced proprioception, such as the inability to feel the foot pedals of vehicle
- ☐ Loss of position sensation
- ☐ Pain of burning requiring maintenance pain medication (include use of gabapentin and pregabalin)
- ☐ Contact-induced discomfort or pain
- ☐ Foot ulceration or infection that affects wearing of footwear or ambulation
- ☐ History of falls
- ☐ None of the above

Please describe the presence of above conditions: ______________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________
12. **Cardiovascular Exam**
   Please provide a 10 year risk estimation of heart disease using the American Heart Association calculator (http://tools.acc.org/ASCVD-Risk-Estimator): _____________ (another risk estimator of cardiovascular disease is acceptable)

   **Patient with no known cardiovascular disease:** Please provide an exercise stress testing to at least 12 METs if the 10 year risk is 10% or more according to the American Heart Association calculator.

   **Patient with known cardiovascular disease:** Please provide a recent (within past 12 months) normal exercise stress test to at least 12 METs.

   Describe the **past history of cardiovascular disease and interventions** (e.g., MI, CABG, PCI, TIAs, stroke):
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

13. **Renal function testing**
   Date of testing: _________________________________
   Serum Creatinine: _______________________________
   Urine microalbumin/creatinine ratio: ________________
   eGFR: _________________________________________

   Has this person been referred to a nephrologist? **Circle one:**    Yes    No    Not indicated

**III. Treating Physician Statement**

Please provide additional information not included above, that may be helpful to the review by the police physician:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Signature of Physician          Date
________________________________________________________________ _____________________________
Printed Name of Physician and Specialty    Telephone Number
4.3.9 – REFERENCES


