SAINT MARY'S HEALTH CARE

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DIABETES SELF MANAGEMENT EDUCATION PROGRAM

DIABETES ASSESSMENT & EDUCATIONAL DOCUMENTATION

Name _____ **D.O.B.** ____/____/___ **Age** _____ **Date** ___/___/____

Family/S.O. _____ **Ht.** _____ **Wt.** _____ **B.P.** _____ **M F**

Referring provider _____ **Insurance** _____

***Type of DM*:** **Type 1** controlled/uncontrolled **Type 2** controlled/uncontrolled **GDM (EDC_____)** **Pre-diabetes**

***Readiness to learn*:** ☐ **Unable to teach** ☐ **Resistant** ☐ **Somewhat Resistant** ☐ **Receptive** ☐ **Very Receptive**

***Factors affecting learning*:** ☐ **Deaf/Hearing Impaired** ☐ **Learning Impaired** ☐ **Financial concerns** ☐ **Language** _____ ☐ **Other** _____ ☐ **Blind/Visually Impaired** ☐ **Dexterity** ☐ **Psychosocial support** ☐ **Interpreter**

***EXERCISE*:** ☐ **Regular routine** _____x day/week/month _____ minutes ☐**ADL** ☐ **Limited due to physical condition**

***MEAL PLAN*:** ☐ **Yes** ☐ **No** ☐ **Carb Counting** _____Meal _____ Snack ☐ **Exchanges** ☐ **Other** _____

***SMBG*:** ☐ **Never** ☐_____**x Day/Week** **Target blood glucose** _____/unsure **Actual BG range** _____

Meter: _____ **Accurate use of log:** ☐ **Always** ☐ **Usually** ☐ **Rarely** ☐ **Never**

HbA1c _____ /unsure **Target HbA1c** _____/unsure **BLOOD GLUCOSE AT THIS VISIT** _____**mg/dL**

***HYPOGLYCEMIA*:** _____**x day/week/month** **Recognize symptoms** ☐ **Yes, at** _____ mg/dL ☐ **No** ☐ **Unsure**

Treats with _____ **Carries treatment:** ☐ **Always** ☐ **Usually** ☐ **Rarely** ☐ **Never**

***DIABETES TREATMENT PLAN*:** ☐ **Diet/Exercise** ☐ **OHA/Insulin** _____
Insulin by: ☐ **Vial/syringe** ☐ **Disposable pen** _____ ☐ **Cartridge/Pen** _____ ☐**Pump** _____

***RISK FACTOR REDUCTION*:** **Diabetes I.D.** ☐ **Yes/ type** _____ ☐ **No** **Annual Flu vaccine** **Yes/No**

Dilated eye exam past year **Yes/No** **Self foot exam** _____x day/week **Pneumonia vaccine** **Yes/No**

Microalbumin test in past year **Yes/No** +/- **Cholesterol check past year** **Yes/No** _____

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