

DSMT Intake Form

Section 1: PARTICIPANT INFORMATION:

Name _____

Address: _____

Home phone: _____ Cell/other phone: _____

Best time to call: _____ Birth Date: _____ Male Female

Participant's primary language: _____

Race/ethnicity: _____ Latino/Latina

Workshop Site Assigned: _____

Workshop Start Date: _____

Class Zero Intake Site: _____

Section 2: BILLING INFORMATION:

Medicare number: _____

Supplement/Advantage plan: _____

Prior diabetic education: Yes No

If yes, what was the class? _____

Where? _____ When? _____ (within a year)

Is Medication Nutrition Therapy recommended by your physician? Yes___ No___

Referring Physician: _____

Address: _____

City/State: _____

Phone: _____ Fax: _____

Referral Source: _____

Section 3: MEDICAL INFORMATION:

Type of Diabetes_____ Age____ Ht_____ Wt_____ BMI____

Most Recent Fasting Blood Glucose (date/result): _____

Most Recent HgbA1c, if available (date/result):_____

Most Recent LDL-C, if available (date/result): _____

1. Are you taking oral medications to treat your diabetes? Yes No

Have you ever taken oral medication to treat your diabetes? Yes No

Name(s) of medication and dosage(s): _____

2. Are you currently taking insulin to control your diabetes? Yes No

Have you ever taken insulin to control your diabetes? Yes No

Name(s) of medication and dosage(s): _____

3. Have you taken any steroids such as prednisone which impacted your diabetes? Yes No

How did it impact your diabetes?_____

4. How often do you measure your blood sugar level?

Never Rarely 1-3 times per month 1 – 3 times per week;

4 – 6 times per week 1-2 times per day 3+ times per day

If you keep a log of your blood sugar level what is your usually range? _____

5. How often are you physically active (e.g., walking, exercise?)

Never Rarely 1–3 times per month Once a week,

Two or more times per week Daily

Please share examples of the types of physically activity

6. Do you follow a specific meal plan? Yes No

If yes, what is your meal plan?

7. Do you use tobacco? Yes___ No___

If yes, what type? Cigarettes_____ Chew_____ Snuff___ Pipe_____ Cigar_____

If you stopped smoking, when was your last use?_____

8. Do you have pain from your diabetes or any other condition? Yes__No__

If yes, describe how this affects you_____

9. Have you been in the emergency room or hospitalized for a condition related to your diabetes in the last 12 months? Yes No

Details:

8. Have you had your eyes checked by a specialist in the last 12 months? Yes No

Results: _____

9. Have you had a foot examination in the last 12 months? Yes No

Results: _____

10. Do you have high blood pressure? Yes No

Name(s) of medication and dosage(s):

11. Do you have pain from your diabetes or any other condition?

If yes, please briefly describe how this affects you: _____

Section 4 - SOCIAL FACTORS

Family Environment and Support:

1. Do you live alone? Yes If no how many people live with you _____
2. Are there relatives or others caring helping you on a regular basis? Yes No
3. Do you prepare your own meals? Yes If no, who prepares them for you?

4. Do you have support from family or others to deal with your diabetes? Yes No
5. Other psychosocial factors impacting diabetes management

Cultural Factors:

1. Is there anything specific to your culture that you think influences your ability to manage your diabetes?

2. “Do your cultural beliefs influence your ability to manage your diabetes?”

3. Are there certain types of foods important to your culture?

4. Does having diabetes or having a serious illness create culture stress?

5. Are there any religious or cultural factors that affect how you eat?

6. Emotional symptoms associated with diabetes (stress, anxiety, depression): “How do you feel about having diabetes?”

Okay Anxious Angry
Afraid Sad Depressed
Overwhelmed “Unsure of what to do, alone”
Additional Comments

Other cultural factors that impact the management of diabetes _____

Section 5 -- Individual Educational Plan:

Paraphrase: The Take Charge of Your Diabetes workshop meets for 6 weeks range of topics. Participants learn in the workshop to work on their own goals related to managing their diabetes. Now, we’re going to create an individual educational plan for you so that you can get the most out of the workshop.

1. Would you like help with any of the following things (Check as many as applicable?)

- ___ Eating healthier meals/following a healthier meal pattern
- ___ Increase my level of physical activity/exercise
- ___ Increase my monitoring of blood sugar
- ___ Increase the support from family or friends
- ___ Set an achievable weight lose goals
- ___ Increase my understanding of diabetes
- ___ Improve my ability to manage stress and/or emotions that effect my diabetes
- ___ Improve my ability to manage my depression
- ___ Increase my ability to work with complications from diabetes (such as medical issues like neuropathy, vision problems, low energy, mobility problems)

___ Increase my ability to use the medical system effectively (for example: better communication with doctors)

___ Increase my ability to give myself injections at appropriate/regular time

2. Identify the top three problems or issues which impact your ability to managing your diabetes: (for example, blood sugar fluctuations; poor diet; depression; or other factors)

3. Identify barriers to managing your diabetes successfully: (physical barriers; language; literacy; appropriateness for self-management)

INDIVIDUAL PROBLEMS/NEEDS/GOALS:

4. Participant's readiness for change (Pre-contemplative; contemplative; preparation; action; maintenance; relapse)

Participant's initial goals:

ACCOMMODATION FOR PARTICIPANT'S INDIVIDUAL EDUCATIONAL NEEDS:

Visual/Learning/Mobility/other disability that needs an accommodation:

Summary of Plan

Instructor's Signature_(RN, RD, PharmD, RPh)_____

Date_____

Section 5: Individual and Collaborative Education Plan

Introduction: *The [Fill in Name of Workshop] Diabetes workshop will meet for 6 weeks and cover a range of topics. Participants will learn about nutrition, exercise, managing stress, communicating with health professionals, managing blood glucose, and skills for goal setting and problem solving. Participants typically use the workshop to work on their own goals related to managing their diabetes.*

If participant is appropriate for and willing to attend the workshop, PQI adds: *Now we're going to create an individual education plan for you so that you can get the most out of the workshop.*

1. Would you like help with any of the following things? (Circle as many as applicable)

- a. Eating healthier meals / following a healthier meal pattern
- b. Increasing / being consistent with exercise
- c. Increasing monitoring of blood sugar
- d. Giving injections at appropriate / regular times
- e. Managing medication usage
- f. Increasing support from family and friends
- g. Losing weight
- h. Understanding more about diabetes
- i. Working with stress and/or other difficult emotions from diabetes
- j. Working with complications from diabetes (medical issues such as neuropathy, vision, low energy, foot, mobility)
- k. Using the medical system with more success and effectiveness
- l. Improving Communication Skills

2. Participant's current problems or issues with managing diabetes: (blood sugar fluctuations, poor diet, depression, other complications)

3. Barriers to learning / coping successfully with diabetes (physical barriers, language, literacy, appropriateness for self-management):

