

Name: _____

Date: _____

Follow Up Plan

Recommendations: Dentist Foot Doctor Eye Doctor Quit Smoking Dietitian Flu

Vaccination Pneumonia Vaccination Diabetes ID Public Health/Visiting Nurse

Support Group _____ Social Worker Other _____

A1c Cholesterol HDL LDL Triglycerides Microalbuminuria

Other _____

Behavior Change Goal:

Specific behavior to be changed _____

How will you change the behavior? _____

How will the behavior change improve your health or quality of life?

Signature _____

Follow Up Assessment

How successful are you with your behavior change goal?

Never Sometimes Usually Always

If you are not successful, why not? _____

Did you follow through with recommendations? (see above) Yes No

If not, why not? _____

How is your current health? Poor Fair Good Excellent

How frequently do you check your blood sugar? _____

What does it range? _____ Do you like the blood sugars you're seeing? _____

How often do you follow your meal plan? N/A Rarely or never Occasionally Often Always

How often do you do a self foot exam? _____ How often are you physically active? _____

How well do you feel you are able to do the following?

Oral medication/Insulin use: N/A Poor Fair Good Excellent

Blood Sugar meter use: N/A Poor Fair Good Excellent

Foot Exam: N/A Poor Fair Good Excellent

How sure are you that you can manage diabetes? Not sure Somewhat sure Very sure

Date(s) of any hospital stays for diabetes since class: _____

My diabetes is a(n): Disaster Burden Problem Challenge Opportunity Other

Write one example of how you used what you learned about diabetes in your class: _____

What has changed in your diabetes care since the classes? _____

FOR INSTRUCTIONAL STAFF ONLY

Additional interventions provided/follow-up needed _____

See Education Record: _____

Signature: _____