BURGESS Health Center

Label

DIABETES SELF ASSESSMENT

PATIENT INFORMATION

Name:	
Are You Currently Working? Yes ☐ No ☐ **Financial Concerns?** Yes ☐ No ☐	**Last Grade of School Completed:**
Language Preference: ☐ English ☐ Other:	
Who else lives with you?	☐ Married ☐ Single ☐ Divorced ☐ Widowed

DIABETES INFORMATION

Is there anything about living with diabetes that causes your stress or distress? ☐ No ☐ Yes : List

How do you handle stress?

What are your feelings about having diabetes?

☐ Frustrated ☐ Angry ☐ Guilty ☐ Depressed ☐ Okay – accepting ☐ Other: _____

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? ☐ Yes ☐ No

If yes, please describe:

Who helps you with your diabetes?

Would you like someone with you at these visits? ☐Yes: please list: _____ ☐No

LEARNING STYLE

How do you learn best? ☐ Listening ☐ Reading ☐ Observing ☐ Doing ☐ Computer (digital)/Smartphone

Do you have any problems with: ☐ Hearing ☐ Seeing ☐ Reading ☐ Speaking

☐ Yes, please describe: ☐ No, I have no problems

Can you read/write written instructions without difficulty? ☐ Yes ☐ No

MEDICAL HISTORY

Do you have any of the following?

	Eye problems		Heart problems		Chronic pain		Lung/breathing problems
	Kidney problems		High blood pressure		Physical limitations		Stomach problems
	Dental problems		High cholesterol		Depression/Anxiety		Numbness/tingling/loss of feeling in hands and feet

MEDICAL HISTORY CONTINUED NEXT PAGE

	Nerve problems		Frequent infections		Sexual problems		Family history of diabetes
	Poor Circulation		Sleep Apnea		Thyroid disorders		

Do you use tobacco? ☐ None ☐ Cigarette ☐ Pipe ☐ Chewing ☐Quit When?

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type of alcohol? How many drinks per day/week/month?

Being Active

Are you physically active? ☐ Yes ☐ No

What type of activity do you do? ☐ Walking ☐ Running ☐ Active job ☐ Strength training (weights, push-ups, sit-ups)
☐ Other _____

Living with Diabetes

Please state whether you agree, are neutral or disagree with the following statements:

If I take care of myself I can help prevent diabetes complications.		Yes		No		Not sure
I have concerns about my finances.		Yes		No		Sometimes
I have a hard time making changes.		Yes		No		Sometimes
I have difficulty paying for my diabetes medications.		Yes		No		Sometimes
It is hard to keep my appointments due to transportation or my schedule		Yes		No		Sometimes
I have concerns about having enough food to eat		Yes		No		Sometimes

How many meals per week do you eat away from home? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5 or more

Do you have any food allergies? ☐ Yes ☐ No If yes, list:

Do you check your blood sugars? ☐ Yes When do you check :
_____ ☐ No

Do you know what your blood sugar target is? ☐ Yes list target:_____ ☐ No

How long have you had diabetes?

Have you had diabetes education before our visit today?
☐ Yes: when?_____ ☐ No

CLINICIAN ASSESSMENT SUMMARY
Pharmacy:
Physical Limitations:
Eye Exam:
Foot Exam:
Dentist:

Nutrition Assessment:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Signature of Clinician **Date**

BURGESS Health Center

Burgess Diabetes Center Diabetes Knowledge Assessment

NAME: _____ DATE:_____

Please circle your answer. It's ok if you do not know the answer to a question. We will talk about any questions you have when we meet.

1. Type 2 diabetes is a condition that happens when:
   A. The body does not make enough insulin.
   B. The muscle cells in your body do not use insulin well or become "resistant".
   C. The liver produces more sugar than your body needs.
   D. All of the above.
   E. I don't know.

2. A Healthy Diet with Diabetes includes:
   A. Eating carbohydrates
   B. Lots of vegetables
   C. Protein foods – like meat or beans
   D. All of the above
   E. I don't know

3. 15 grams of carbohydrate equals one carbohydrate choice: If you eat a bagel with 30 grams of carbohydrates in it how many carbohydrate choices is this?
   A. 1
   B. 2
   C. 4
   D. I don't know.

4. Physical Activity helps:
   A. Lower my blood sugar /A1C
   B. Lower my blood pressure
   C. Improve my cholesterol
   D. All of the above
   E. I don't know

5. Keeping my blood sugar, blood pressure, and cholesterol at a healthy level lowers my risk for heart attack and stroke.
   A. True
   B. False
   C. I don't know

-OVER-

6. Checking my blood sugar daily is a way to see if my diabetes medication, food, and activity are working to manage my blood sugar.
   A. True
   B. False
   C. I don't know.

7. Ways to help handle the stress of managing diabetes includes:
   A. Being active
   B. Being involved with church or a time to reflect
   C. Having a hobby
   D. Attending a support group
   E. All of the above
   F. I don't know

8. Sometimes unexpected things can affect your blood sugar. When this happens problem solving with your diabetes educator can help.
   A. True
   B. False
   C. I don't know

9. How often should your healthcare provider do a foot exam to evaluate feeling in your feet?
   A. Every 3 months
   B. Yearly
   C. Every 2 years
   D. I don't know

10. Do you know the date of your foot exam?
   A. Yes: Date completed:_____
   B. No

11. Do you know who to call if you have questions or concerns about your diabetes care?
   A. Yes
   B. No

12. Do you feel comfortable managing your diabetes at home?
   A. Yes
   B. Somewhat comfortable
   C. No

BURGESS Health Center

DIABETES SELF MANAGEMENT EDUCATION PLAN OF CARE

Diabetes education is recommended at four different times in your life:

- At diagnosis
- Annually and/or not meeting treatment targets
- When complicating factors develop
- When transitions in life or care occur

This plan of care includes persons with Type 1, Type 2, Gestational diabetes and diabetes in pregnancy.

_____Individual _____ Group Diagnosis: _____ **_____ In Person** **_____ Telehealth: ___Audio only ____Audio-Video Combination**
Up to 10 hours of education initially and up to 2 hours annually **GOAL:** Provide education and support for persons with diabetes on: ☐ What diabetes is and treatment options ☐ Healthy Eating ☐ Healthy Coping ☐ Being Active ☐ Taking Medication ☐ Monitoring ☐ Reduce Risk (treating acute and chronic complications) ☐ Problem Solving and behavior change strategies

Number of visits anticpated: _____

How often do you plan to come for visits: _____

This care plan was reviewed with the patient, who indicated this plan is acceptable and he/she would participate.

_____

Patient Signature **Date** **Staff Signature** **Date**

BURGESS
Health Center

Burgess Diabetes Center Phone and other Message consent

Name:			**Birthdate:**
Address:	**City:**	**State:**	**Zip Code:**

Phone number:

Home: _____

Cell:_____

Work:_____

Consent For Burgess Diabetes Center to leave a message: Please check all that apply.

- ☐ I give my consent for Burgess Diabetes Center to leave a message on the answering machine of the phone number listed above.
- ☐ I give my consent for the following person(s) to receive messages for me:
  Name: _____ Relationship to you: _____
  Phone number: _____

  Name:_____ Relationship to you:_____
  Phone number: _____
- ☐ I give consent to leave a message by secure email at the following email address:
  _____
- ☐ I give consent for an unsecure text message to the following number:

Patient Signature: _____ Date: _____

Witness: _____
Date:_____