DSMES Assessment and Individualized Education Plan

Today's Date: ____________________

Section 1: PARTICIPANT INFORMATION

Name: ____

Address: ____

Home phone: ____________________ Mobile/other phone: _________________

Best time to call: ______________ Birth Date: ___________ Male ☐ Female ☐

Participant's primary language: _____________________________

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐
Native Hawaiian or Other Pacific Islander ☐ White ☐

Ethnicity: Hispanic or Latino: Yes ☐ No ☐

Section 2: BILLING INFORMATION

Medicare number: ____

Medigap/Advantage plan: ____

Prior diabetes education: Yes ☐ No ☐

If yes, what was the class? ____

Where? ______________________ When? __________________ (if within a year)

Is Medication Nutrition Therapy recommended by your physician? Yes ☐ No ☐

Referring Physician: ____

Address: ____

Phone: _______________________________ Fax: _____________________

Referral source: ____

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

2. Do you have high blood pressure? Yes ☐ No ☐
   Name(s) of medication and dosage(s) you are taking for high blood pressure:
   ____

3. Are you taking medication for high cholesterol (i.e., statin drugs)? Yes ☐ No ☐
   Name of medication for high cholesterol: ____________________________

4. Are you taking insulin to control your diabetes? Yes ☐ No ☐
   Name(s) of medication and dosage(s): _______________________________

5. Have you taken any steroids, such as prednisone, that impacted your diabetes? Yes ☐ No ☐
   How did it affect your diabetes?______________________________________

6. 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 or more times per day ☐

7. If you keep a log of your blood sugar level, what is your usual range?
   ____

8. How often are you physically active (walking, gardening, or other exercise)?
   Never ☐ Rarely ☐ 1-3 times per month ☐ Once a week ☐
   Two or more times per week ☐ Daily ☐
   What type of activities? ____

9. Have you had any falls in the past month? Yes ☐ No ☐
   If yes, how many times ______? How did you fall and where were you hurt?____
   ____

SAMPLE

10. Do you follow a specific meal plan? Yes ☐ No ☐
    If yes, what is your meal plan? ______________________________

11. Do you use tobacco currently? Yes ☐ No ☐
    What type: Cigarettes ☐ Chew ☐ Snuff ☐ Pipe ☐ Cigar ☐ How long? _____
    If you used tobacco in the past and quit, when was your last use? ________

12. Do you have pain from your diabetes or any other condition? Yes ☐ No ☐
    If yes, please rate your pain on a scale of 1-10, with 1 meaning you have slight pain and 10 being the worst possible pain?
    1 2 3 4 5 6 7 8 9 10
    How does the pain affect you? ______________________________
    How do you manage your pain? ______________________________

13. Have you been in the emergency room or hospitalized for your diabetes or a condition related to your diabetes in the last 12 months? Yes ☐ No ☐
    Describe: ______________________________

14. Do you have difficulty with any of the following?
    Physical difficulty ☐ Hearing ☐ Eyesight ☐
    Please describe: ______________________________
    ____

15. Have you had your eyes checked by a specialist in the past 12 months?
    Yes ☐ No ☐ Results: ______________________________

16. Have you had a foot examination in the last 12 months? Yes ☐ No ☐
    Results: ______________________________

17. Do you have any complications related to your diabetes? Yes ☐ No ☐
    If yes, please list them: ______________________________

18. Do you use alcohol or other drugs? Yes ☐ No ☐
    If yes, How often: ______________ How much: ______________

Section 4: SOCIAL, EMOTIONAL, AND FINANCIAL FACTORS

1. Do you live alone? Yes ☐ No ☐
   If no, who do you live with? ______________________________

2. How would you describe your relationships with your family and friends?
   ____

3. Do you have someone close to talk with about your condition and concerns?
   Yes ☐ No ☐ Who: ______________________________

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4. Are you able to prepare your own meals? Yes ☐ No ☐
   If no, who prepares them for you? ________________________________

5. Do you receive the support and assistance that you need from others to perform your daily self-care activities, including dressing, bathing, mobility, and toileting? Yes ☐ No ☐
   Describe: ____

6. Do you receive the support you need to manage your health and personal affairs (for example, paying bills, buying groceries, getting to doctor's appointments, filling prescriptions, running errands, etc.)? Yes ☐ No ☐
   Describe: ____

7. Do you have concerns about being able to pay for food or make proper food choices? Yes ☐ No ☐
   Describe: ____

8. Do you have concerns about being able to pay for your medicine?
   Yes ☐ No ☐ If yes, what do you do? ____________________________

9. Have you ever been diagnosed with depression? Yes ☐ No ☐

10. Over the past two weeks, how often have you felt down, depressed, or hopeless?
    Not at all ☐ Several days ☐ More than half of the days ☐
    Nearly every day ☐

11. How is your sleep?
    Sleeping as usual ☐ Slight difficulty ☐ Sleep reduced by 2 hours ☐
    Getting less than 3 hours of sleep a night ☐

12. How is your energy?
    As much as ever ☐ Less than before ☐ Not enough to do much ☐
    Not enough to do anything ☐

13. Do you ever feel lonely or socially isolated?
    Never ☐ Seldom ☐ Sometimes ☐ Often ☐

14. Which of the following words describe how you feel about having diabetes?
    Accept it ☐ Anxious ☐ Angry ☐ Afraid ☐ Sad ☐ Depressed ☐
    Overwhelmed ☐ Frustrated ☐ Unsure of what to do ☐ Alone ☐
    Hopeful ☐ Motivated to learn how to manage it ☐
    Comments: ____

SAMPLE

15. Other psychosocial factors impacting diabetes management:
____

Section 5: CULTURAL FACTORS

1. Do you have any cultural beliefs or practices that affect your ability to manage your diabetes, including eating healthy meals regularly to stabilize your blood sugars?
   If yes, please describe: ____

2. Are there certain types of foods important to your culture that affect the way you eat?
   If so, please describe: ____

3. Does having diabetes keep you from performing or participating in activities that are important for your culture? Yes ☐ No ☐
   If yes, describe: ____

Section 6: INDIVIDUALIZED EDUCATIONAL PLAN

1. Which of the following would you like help with? (Check as many as apply)
   ___ Eating healthier meals/following a healthier meal pattern
   ___ Increase my level of physical activity/exercise
   ___ Increase blood sugar level monitoring
   ___ Increase support from family or friends
   ___ Set an achievable weight loss goal
   ___ Increase my understanding of diabetes
   ___ Improve my ability to manage depression
   ___ Improve my ability to manage stress and/or emotions that affect my diabetes
   ___ Increase my ability to manage symptoms and complications from diabetes (such as neuropathy, vision problems, low energy, pain, mobility problems)
   ___ Improve proper medication use and management
   ___ Increase my ability to work with my doctor and other health care providers (for example: better communication)
   ___ Increase my ability to give myself injections at appropriate/ regular time

2. What are the top three problems or concerns that affect your ability to manage your diabetes (for example, blood sugar fluctuations; poor diet; depression; or other factors):
   ____
   ____
   ____

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3. Identify barriers that affect participant's ability to manage diabetes successfully (for example, physical barriers; language; literacy; social support):
   ____

Section 7: READINESS FOR CHANGE AND GOALS

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

2. Personal Diabetes Self-Management (SMART) Goals:
   ____
   ____
   ____
   ____
   ____

Section 8: ACCOMMODATION FOR PARTICIPANT'S INDIVIDUALIZED EDUCATIONAL NEEDS

☐ Health Literacy Needs: ____
☐ Preferred Language: ____
☐ Preferences for receiving information____________________________________
☐ Visual/Learning/Mobility/other disability that needs an accommodation:
____

Section 9: INTERVENTIONS AND SUMMARY OF PLAN

☐ Individual Interventions: Frequency and duration: ________________________
Describe: ____
☐ Group Intervention: Chronic Disease Self-Management Group Program
- Duration: Six Week Group Intervention for diabetes self-management education and support
- Frequency: One session per week/2.5 hours each in a group setting
- Targeted intervention to provide participants with the knowledge, self-confident, support, and skills to manage their diabetes

☐ Workshop Site Assigned: ____
☐ Workshop Start Date: ____
☐ Class Zero Intake Site: ____

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Summary of Plan:

____
____
____
____
____

☐ Participant understands and is in agreement with the plan and goals

____

Clinician's Signature Credentials Date

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