SAMPLE
CDSMP Follow-Up Plan and Assessment Form

HEALTH BEHAVIOR AND ASSESSMENT INTERVENTION (HBAI)

Name: ____________________________ Date: ________________

FOLLOW UP PLAN

Recommendations:
☐ Dentist ☐ Foot Doctor ☐ Eye Doctor ☐ Quit Smoking
☐ Dietitian ☐ Flu Vaccination ☐ Pneumonia Vaccination
☐ Public Health/Visiting Nurse Visit ☐ Support Group
☐ Social Worker ☐ Other
☐ 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 always 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 often do you follow your meal plan?
☐ N/A ☐ Rarely or never ☐ Occasionally ☐ Often ☐ Always

If you do not always follow your meal plan, why not?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How often are you physically active? ________________________________

How well do you feel you are able to take your home medication as prescribed by your doctor(s)?
☐ N/A ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How sure are you that you can manage your chronic disease?
☐ Not sure ☐ Somewhat sure ☐ Very sure

My chronic disease is a(n):  
☐ Disaster ☐ Burden ☐ Problem ☐ Challenge ☐ Opportunity ☐ Other

Write one example of how you used what you learned about self-managing chronic disease in your class:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What has changed in your chronic disease care since the classes?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

FOR INSTRUCTIONAL STAFF ONLY

Additional interventions provided/follow-up needed
☐ See Education Record: _________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature: ____________________________________________