

# DIABETES EDUCATION RECORD


Name: \_\_\_\_\_ MR #: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Assessment Summary:**

Topics of greatest interest:

Key needs:

Skills review:

Assessment Summary* Date:	Basic Diabetes Self-Management Skills	Instruction Given					Goal reached
		<i>Initial objective when taught under the date.</i>					Date/initial
1 2 3 0		Date:	Date:	Date:	Date:	Date:	
<b>1 2 3 0</b>	<b>Monitoring</b>						
	Demonstrates monitoring skill						
	Monitors BG according to plan						
	Uses results of monitoring						
Comments:							
<b>1 2 3 0</b>	<b>Meal Plan</b>						
	Basic healthy eating guidelines						
	Has meal plan						
	Uses meal plan						
	Counts carbohydrates						
	Reduced fat guidelines						
	Uses food labels						
	Dining out guidelines						
Comments:							
<b>1 2 3 0</b>	<b>Physical activity</b>						
	Incorporates physical activity						
	Follows safe exercise guidelines						
Comments:							
<small>The information contained in this message is intended for the exclusive use of the addressee or addressee's authorized agent. This message is privileged and confidential or may contain proprietary or sensitive information. It shall not be copied or disseminated except as directed by the addressee. Any unauthorized use, copying or dissemination of this message or its contents is prohibited. If you have received this fax in error, please advise the sender immediately and return this message and any copies to our office immediately.</small>							
 <b>JOSLIN DIABETES CENTER AFFILIATE at St. Vincent Charity Hospital</b> Phone: 216-363-3301 Fax: 216-363-3304							



ST. VINCENT CHARITY  
MEDICAL CENTER

2351 EAST 22ND STREET  
CLEVELAND, OH 44115  
stvincentcharity.com

A Ministry of the Sisters of Charity Health System

PATIENT LABEL



**MR.JDCDEUREC**

**Additional Outcomes** (track at least one):

	Target	Pt Target Date:	Baseline Date:	Follow-up Date:	Follow-up Date:	Follow-up Date:
FBG						
Glycohemoglobin	<7%					
Total Cholesterol	<200					
LDL-chol	<100					
Microalbumin						
Weight (height: _____)						
Blood pressure	<130/80					
PAID score						
# hospital/ER visits in past mo.						
# hypoglycemia						
# lost school/work days						

**Patient Health Behavior Goals**

**Met Goals? Date**

	<u>all</u>	<u>some</u>	<u>not at all</u>
_____	1	2	3
_____	1	2	3
_____	1	2	3

Completed post-program assessment tool (date: \_\_\_\_\_)

**Self-Management Plan:**

Medication instructions: \_\_\_\_\_

Exercise / Activity instructions: \_\_\_\_\_

Monitoring: \_\_\_\_\_

Meal plan: Calories \_\_\_\_\_ ; Carb \_\_\_\_\_ ; Protein \_\_\_\_\_ ; Fat \_\_\_\_\_ ; Other \_\_\_\_\_

<i>time:</i>	<b>Breakfast</b>	<b>Snack</b>	<b>Lunch</b>	<b>Snack</b>	<b>Dinner</b>	<b>Snack</b>
	_____ : _____	_____ : _____	_____ : _____	_____ : _____	_____ : _____	_____ : _____
Carbohydrates						
Vegetables						
Meat / Protein						
Fats						

**Comments Class / Visit / Phone notes / Follow-up plans:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Date**                      **Initials**                      **Signature:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PATIENT LABEL