



DIABETES MANAGEMENT PROGRAM
NEEDS ASSESSMENT

CDM-002 (9-04)

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LOCATION: [] BRICK [] JSMC [] POINT [] RMC [] OTHER

DATE [] INPATIENT [] OUTPATIENT [] GESTATIONAL [] HOME CARE [] PEDI

Name: Phone ()

Address:

Physician Responsible for Diabetes Management:

Physician Responsible for Care in Hospital:

TYPE OF DIABETES

- [] Type 1 [] Gestational, if so [] Due Date
[] Type 2 [] Using Insulin [] Oral Agents [] Diet and Exercise Only

GENERAL INFORMATION

When was diabetes diagnosed: Date

Birthdate: Sex: Ethnic Group:

Occupation:

Work hours:

Highest level of education achieved:

- Potential barriers to learning? [] visual [] hearing [] language [] literacy [] physical [] emotional
[] cultural and religious [] motivation [] cognitive [] financial [] other

Are you satisfied with your diabetes control? [] Yes [] No

Any previous diabetes education? [] Yes [] No When Where

Describe type of education

RELATIVES WITH DIABETES

- [] Parent(s) - (M, F)
[] Grandparent(s)
[] Identical Twin
[] Siblings

LIVING ARRANGEMENTS

- [] Alone
[] With Family/Ages
[] Other

Identified Support Person for Instruction? [] Yes [] No

Name: Relationship:

Self Rated Health 1 - 5 (1-poor; 5-excellent)

Coping Strategies/Current Major Stress:

EXERCISE:

Type:
Frequency & Duration:
min. days/week

TOBACCO USE:

- [] Never
[] Quit (year)
[] Packs/Day

ALCOHOL USE:

- [] Never
[] Number/Week

DIABETES MEDICATION:

Table with 7 columns: Insulin Units, N/, R/Humalog, L/, 70/30, 50/50, Insulin Pump. Rows include AM, Lunch, Dinner, Bedtime.



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Do you rotate sites and if so how

Glucagon kit available at home [] Yes [] No

Oral Agents: Type: Dose: Frequency:
Type: Dose: Frequency:
Type: Dose: Frequency:

MONITORING AND CONTROL HISTORY

Table with 3 columns: Monitor, Usual results range, Frequency. Rows include Blood Glucose Testing and Urine Ketone Testing.

Issues concerning monitoring:

Hypoglycemia:

Symptoms:
Frequency:
Treatment:

Hyperglycemia:

Symptoms:
Frequency:
Treatment:

Sick Day Management:

Monitoring [] Yes [] No Frequency:

Sick Day Foods:

Admission or last blood pressure reading:

Admission or last blood glucose:

Admission or last HgbA1C:

Foot Care Daily? [] Yes [] No Frequency:

Note General Condition of Skin of Feet

HEALTH PROBLEMS

- Heart, Elevated Cholesterol, High/Low Blood Pressure, Infections, Stomach/Intestines, Circulatory, Problem with Sexual Response, Other Conditions, Skin Changes, Nerves, Kidney Problems, Eye Problems, Currently Pregnant, Times Pregnant, Number of Children



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LOCATION: BRICK JSMC POINT RMC OTHER _____

MEDICATIONS FOR OTHER HEALTH PROBLEMS: _____

HEALTH CARE UTILIZATION:

Frequency of: Dental Exams: _____ M.D. Visits: _____ #/yr

Eye Exams (Ophthalmology): _____ Last Exam: _____ Podiatric Exam: _____ Last Exam _____

Number of hospitalizations in last year _____ Reason(s): _____

Number of Emergency visits in last year _____ Reason(s): _____

NUTRITIONAL HISTORY

Height: _____ Weight: _____ How long at present weight _____ Desired Weight _____

Special Diet: _____ Food allergies _____

How often eat out: _____ Religious/ethnic preferences _____

BREAKFAST	LUNCH	DINNER	SNACKS

Does own shopping: Yes No

Does own cooking: Yes No

NEEDS ASSESSMENT SUMMARY

INDIVIDUALIZED EDUCATION PLAN:

DIABETES EDUCATOR: _____

This plan was mutually agreed upon by Educator and patient

DISCHARGE/FOLLOW-UP PLAN

SIGNATURE: _____