DIABETES EDUCATION AND WELLNESS

Welcome and thank you for choosing Diabetes Education and Wellness.
We are pleased that you have chosen us. It is our responsibility to deliver the best care possible to you.

We understand the nature of your visit and respect your time and privacy. For this reason, we ask you to complete few forms and it is best we receive these forms prior to your first appointment. You can fax the forms to our secure fax (732 876 3059) or email to dew@diabeteseduandwellness.com

We ask you to bring items listed below to make your first visit most effective.

1. If using a Blood Glucose meter and test strips please bring to appointment. (If you have a journal of meals and blood sugar, kindly bring them as well.)**Please bring your glucose meter andtest strips to all your appointments with us.**
2. List of healthcare providers and your last appointments with them.
3. List of your pharmacy. Including the name of your diabetes equipment suppliers.
4. Insurance card and Identification.
5. Copy of your most recent bloodwork if available.
6. Copy of your EKG if available.

All co-pays are expected at the time of service, unless a prior agreement has been made.

If you need to reach us after hours, please leave your message on our voicemail. It is checked regularly. Do not forget to state your name and the best number for us to call you back.

Finally, we understand that appointments sometime need to be changed, so we ask you to call us in advance if you cannot keep your scheduled appointment.

Sincerely,

The Staff of DEW

Diabetes Education and Wellness
1910 Route 35, Oakhurst, NJ 07755
Tel: 732-676-8381 Fax: 732-876-3059

Email:dew@diabeteseduandwellness.com
www.diabeteseduandwellness.com

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Diabetes Education Participant Intake Form

Section 1: PARTICIPANT INFORMATION:

Name: Last: _____ First: _____
Address: _____
Phone: _____ Best time to call: _____**Ok to leave message: _____**
Birth Date: _____ __Social Status: ____ Gender: _____Sexual orientation:_____
Participant's primary language: _____ _____
Ethnicity: Caucasian___ African American ___ Native American ___ Hispanic /Latino_____ Asian___
Pacific Islander ____Other:_____ Not wanting to participate_____

Section 2: BILLING INFORMATION: (see attached)

Prior diabetic education: Yes/No **If yes**, Where? _____When?_____
Referring Physician: _____Phone #_____

Section 3: FAMILY ENVIRONMENT AND SUPPORT:

1. Do you work? Yes____No____ Retired_____ Disability___ Unemployment____
2. Do you live alone? Yes____ No___ If no, how many people live with you? _____
3. Who is your primary caregiver? _____
   Do you prepare your own meals? Yes___ No___ If no, who does?_____
4. Do you have support from family or others to deal with your diabetes? Yes_____No_____
5. Other psychosocial factors impacting diabetes management: _____

Section 4: MEDICAL INFORMATION:

Diabetes management team:

	Name	Last Visit	Phone or city
PCP			
Endocrine			
Ophthalmology			
Pharmacy	See medication list ATTACHMENT		
Psychology			
Exercise/Gym			
Podiatry			
Dietitian			
Cardiology			
Dentist			

Labs:

	HgbA1c	LDL-C	Fasting BG
Date			
Result			

Diagnosed When? How: Bloodwork or Symptoms or _____

Diabetes type: Type 1	Type 2	Gestational	Don't Know

Women Only: *Number of pregnancies _____ Number of live births _____*
Currently pregnant? Yes___ No___ *Planning to get pregnant?* Yes___ No___
History of gestational diabetes?____
Had a baby weighing 9 lbs. or more at birth? Yes___ No___
Contraceptive method _____

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1. Are you currently taking oral medications for diabetes? **MED LIST ATTACHMENT**
   Year started using oral medication to treat your diabetes_____
2. Are you currently taking insulin to control your diabetes? **MED LIST ATTACHMENT**
   Year using insulin to control your diabetes_____
3. How often do you measure your blood sugar level? ___
   Have you ever had less than 70? : Yes___ No___
   Have you ever had more than 250? : Yes___ No___
   Brand of Monitor_____
4. Activity :Home: Inactive___ Moderately Inactive ____Active____ Moderately Active _____
   Work: Inactive___ Moderately Inactive ____Active____ Moderately Active _____
   Exercise: _____at _____per week; _____min/hours per session
   Do you have physical limitations? Yes___ No___
5. Do you follow a specific meal plan? **EATING PATTERN Questionnaire ATTACHMENT**
   Have you ever tried to lose weight? **SEE WEIGHT HISTORY ATTACHMENT**
6. How many hours of sleep do you get?_____ DO you have sleep Apnea?_____
   Any sleep study done?_____DO you use CPAP or BiPAP_____

Medical History

Smoking History: Never	Current	Former	
Vaccine: Flu:	**Pneumonia:**		
Alcohol	No:	Yes	How many: _____per_____
High Blood Pressure	Yes	No	Year Dx:
GERD	Yes	No	Latest Endoscopy date:
High Cholesterol	Yes	No	Year Dx:
Heart Disease	Yes	No	Year Dx:
Asthma	Yes	No	
Arthritis	Yes	No	
Polycystic Ovarian Syndrome	Yes	No	
Leg Ulcers Leg discoloration	Yes	No	
Cancer	Yes	No	Year Dx: Type:
Depression	Yes	No	
COPD	Yes	No	Year Dx:
PE(blood clot in lungs)	Yes	No	Year Dx:
DVT(blood clot in legs)	Yes	No	Year Dx:
Stroke or TIA (Mini Stroke)	Yes	No	When?
Thyroid Disorder	Yes	No	Surgery: Yes /No Date
Kidney Disorder	Yes		Year Dx: Dialysis? Yes No
Bleeding Disorder	Yes	No	
Liver Disorder	Yes	No	
SURGERY/when:			
Bariatric SURGERY	Yes	No	When:

Ambulation:	Independent:	Assisted: Type of assistive device:	
Activities of daily living	Independent	Dependent Partial	Dependent Total

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Section 5: Cultural Factors

1. Is there anything specific to your culture that you think influences your ability to manage your diabetes?
   _____
2. Do your cultural beliefs influence your ability to manage your diabetes?_____
3. Are there certain types of foods important to your culture? _____
4. Does having diabetes or having a serious illness create culture stress? _____
5. Are there any religious or cultural factors that affect how you eat? _____
6. How do you feel about having diabetes (ex: Okay, Anxious, depressed, and overwhelmed)
   _____
7. Other cultural factors that impact the management of diabetes? _____

SECTION 6:

1. Would you like help with any of the following things (Check as many as applicable):

____Eating healthier
____Being physically active
____Reducing the risk of complications
____Coping with stress and emotional issues
____Taking medications as prescribed
____Giving myself injections correctly
____ Communicating better with my Doctor/Providers
____Monitoring blood glucose
____Solving problems in unusual situations(low/high BSugar,Sick day)

2. Identify top three problems you struggle with your diabetes: **(for example, blood sugar fluctuations; poor diet; depression; or other factors)**

I. _____
II. _____
III. _____

3. Identify barriers to managing your diabetes successfully.

Do you have difficulty with any of the following?
Seeing ____ Reading___ Writing ___ Hearing ___
Language___ Primary Language:_____
Physical difficulty:_____
List barriers not mentioned: _____

4. How do you learn best?

Written materials___ Verbal Discussion_____ Role playing____ Computer_____
Demonstration_____ Other:_____

Individual Problems/Needs/Goals:

Participant's readiness for change:

_____I am not considering any kind of changes in my habits at this time
_____I am considering making change in the next year
_____I am considering making a change in 6 months
_____I am considering making a change in 6 weeks
_____I have already started making a change making a change

Please list any changes you have made or are considering making because of diabetes_____
Why is this change important to you?_____
What will happen if you don't make this change?_____
Is there anything in particular you want to learn from your instructors?_____

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Weight History

Current weight: _____ lbs. How long have you been at your present weight? _____yrs
Highest weight in the last 10 years? ____lbs. Lowest weight in 5 years?_____lbs.
Physical symptoms due to weight gain:_____
Psychosocial symptoms due to weight gain:_____
Previous use of medically supervised weight management? Yes / No
Provider or Clinic City: Treatment Dates: Type of Treatment: _____
Have you tried diet pills? Yes / No If yes, please list: _____How long? _____
What do you think contributed to weight gain? _____
What is your primary reason for wanting to lose weight?_____
Are you willing to adapt to recommended dietary and activity changes?_____
What do you think is the most challenging part of weight management?_____

Please check all that you have tried **IN THE LAST 10 YEARS. (if not listed please write-in)**

	Year	Weight Loss (lbs.)/over how long?		Year	Weight Loss (lbs.)/over how long?
Atkins			Medifast		
Acupuncture			Nutrisystem		
Calorie Counting			Nutritionist		
Diet Center			Optifast		
Fad Diet			Overeaters Anonymous		
HCG					
Herbal Diet			Pritikin		
Health Spa			Self-Diet		
High Protein			Slim Fast		
Hypnosis			South Beach		
Jenny Craig			Weight Watchers		
LA Diet			Zone		
Low Carbohydrate			Other:		

Do you have a medical living will?____ If no, do you want information? _____
Emergency Contact:_____ Relationship:_____
Phone: _____ **Ok to leave message?**_____

Signature: _____ Date: _____

***Thank you for filling out this information. It will help our staff in preparing your diabetes education plan. Please bring this questionnaire to your first appointment with us*.**

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For Office use:

ACCOMMODATION FOR PARTICIPANT'S INDIVIDUAL EDUCATIONAL NEEDS:

Visual/Learning/Mobility/other disability that needs an accommodation:

_____

_____

_____

Summary of
Plan:_____

_____

DSME/T Staff Signature _____Date_____

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Medication list

NAME:_____**Date:**_____

Allergies _____

Vaccinations: Flu shots? Yes__ No__ Date of last flu shot: _____

P**neumonia shot**? Yes__ No__ Date of last pneumonia shot: _____

Medication & Dose	Times Taken	Prescriber
Diabetes Pills: 1.		
2.		
3.		
4.		
Insulin: 1.		
2.		
Other Injected: 1.		
Cholesterol: 1.		
2.		
3.		
BP/heart medications: 1.		
2.		
3.		
Thyroid medication: 1.		
2.		
Blood thinners: 1.		
Anti-anxiety/Antidepressant: 1.		
2.		
Other : 1.		
2.		
3.		
4.		
5.		
6.		

LOCAL_____ Phone:_____Fax:_____

Mail away_____ Phone:_____Fax:_____

Diabetes supplies:_____ Phone:_____Fax:_____

Wellness…learn it, earn it. Don't quit.™

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Eating Questionnaire

Name:_____ Date: _____

1. Have you received nutrition counseling in the past: YES No
   If yes where_____
2. Do you follow a special diet? YES NO
   Diabetic____ Low Sodium____ Low Fat____ Vegetarian____ High protein ____Raw ____Other:_____
3. What meal do you eat regularly?
   Breakfast_____Lunch_____Brunch_____Dinner_____
4. How often do you snack?
   Mid-Morning: _____Mid PM: _____Evening _____Late night _____Throughout the day_____
   What is your favorite snack? _____
5. How often do you eat out or order out? Daily_____ Weekly _____Monthly _____Other_____
   What kind of foods?_____

6. How many times per day do you eat the following :	Never	Less than 1	1-2	3-5	6-8	9-11	Other
Starch(Beans, Rice, Pasta,Breads)							
Fruits							
Vegetables							
Dairy (milk, yogurt)							
Meat, Fish,							
Fat(butter, mayonnaise, oils, salad dressings)							
Nuts							
Cheese							
Sweets(candy, cakes)							

7. Please write down the amounts of each beverage drink and how much per day?
   Water:_____ Juice:_____ Alcohol_____
   Coffee:_____ Regular Soda_____ Other:_____
   Tea:_____ Diet Soda_____
8. Do you use any meal replacements? YES NO
   If yes what and how often:_____
9. Which eating habits do you like to change? _____
10. Is there anything in particular you want to add?_____
    _____

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HIPAA AUTHORIZATION FORM

Patient's Full Name _____ **Medical Record Number** _____

Address _____ **Patient's Date of Birth** _____

City, State Zip Code _____ **Patient's Telephone Number** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is **authorized to use or disclose information abo**ut me:
   _____***Diabetes Education and Wellness***_____

   The following **person (or Facility) may receive** disclosure of protected health information about me:

   His/her/its Name and Relationship: _____

   Address: _____

   Telephone Number: _____

2. The specific information that should be disclosed is (please give dates of service if possible):

   All or Please specify: _____

   _____

   _____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying **Diabetes Education and Wellness** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for _____

_____	_____	_____
Signature of Individual* (The person (pt.) about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

BEST WAY TO COMMUNICATE WITH PATIENT

Leave message YES NO	**Leave message YES NO**	**YES NO**
Cell phone:	**Home Phone:**	**Family:**

EMAIL:_____

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Consent for Treatment

1. I _____ (patient name) consent to the provision of care, diagnosis /or treatment by give permission for Diabetes Education and Wellness.

2. I acknowledge and confirm that I am mentally capable of giving informed consent to the provision of care, diagnosis and/or treatment and I am not subject to duress or under undue influence.

3. I allow Diabetes Education and Wellness to file for insurance benefits to pay for the care I receive.

   I understand that:
   - Diabetes Education and Wellness will send my medical record information to my insurance company.
   - I authorize Diabetes Education and Wellness to submit claims to my health insurance provider and can represent me in discussing information relevant to the submitted claim.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

4. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my provider.

_____ _____
Participant's Signature Date

_____ _____
Parent or Guardian Signature Date
(for children under 18)

_____ _____
Print name

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Check one: Pre-program ☐ Post-Program ☐

Date _____ Name: _____

The survey will be done before your first session and after the last class. Please circle a number from 1 – 5 to rate how sure you are about doing the task listed. The numbers are in a range; number 1 is the least of the scores and number 5 is the best.

Self-Care Behavior	Confidence Level
1. How sure are you that you can check your blood sugar correctly?	1 Not at all sure 2 3 4 5 Very sure
2. How sure are you that you know how to make healthy food choices?	1 Not at all sure 2 3 4 5 Very sure
3. How sure are you that you can tell which foods are carbohydrates?	1 Not at all sure 2 3 4 5 Very sure
4. If you are taking medicine – How sure are you that you know about your diabetes medicine and the possible side effects?	1 Not at all sure 2 3 4 5 Very sure
5. How sure are you that you know how to exercise regularly and safely?	1 Not at all sure 2 3 4 5 Very sure
6. How sure are you that you can find diabetes information and support when you need it?	1 Not at all sure 2 3 4 5 Very sure
7. How sure are you that you can notice and then do the right things for a low blood sugar reaction?	1 Not at all sure 2 3 4 5 Very sure
8. How sure are you that you can check your feet for problems and take care of them properly?	1 Not at all sure 2 3 4 5 Very sure
9. How sure are you that you can work with your doctor to get the complete, regular diabetes exam?	1 Not at all sure 2 3 4 5 Very sure

Please do your best to answer the question below: Circle the correct answer.

1. My A1C level is: _____ (write in) I Don't Know _____
2. The goal is for my A1C is:
   a) 6.5% or below c) 10%
   b) 7.5% or below d) Don't know
3. When I first wake up, my blood sugar level should be:
   a) 80-140 c) under 70
   b) 70-110 d) Don't know
4. Two hours after I eat, my blood sugar level should be:
   a) under 70 c 160-200
   b) 80-140 d) Don't know
5. The highest blood pressure for people with diabetes should be:
   a) 200/140 c) 130/80
   b) 140/90 d) Don't Know
6. I should see my doctor for diabetes every:
   a) 3 to 6 months c) 5 years
   b) year d) Don't know