FAIRFIELD MEMORIAL HOSPITAL
EXCELLENCE IN COMMUNITY HEALTHCARE

Diabetes Self-Management Program

Material that will be covered

Session 1:
At this visit we will go over your current plan of care and your self- knowledge of Diabetes. I will assess your basic educational needs and what will need addressed in session 2. We will cover a majority of the topics listed to the right as well as answer any questions you may have. A meter will be provided free of charge.

Session 2:
This visit is a follow up on how your self-management skills are working for you. We will review session 1 materials, answer any questions you may have, and finish topics not already addressed.

Phone follow-up:
I will be calling you at 1, 3,6, and 12 months to see how you are managing on your own and answer any questions you may have.

- What is Diabetes?
- Signs and Symptoms of Hyperglycemia (High Blood Sugar)
- Signs and Symptoms of Hypoglycemia (Low Blood Sugar)
- How to treat High and Low Blood Sugars
- Sick-day Management
- Monitoring Blood sugars & Meter usage
  - How to store your meter and supplies
- Prevention, detection and treatment of chronic complications
  - Nephropathy (Kidney Disease)
  - Retinopathy (Disease of the eye)
  - Neuropathy (Nerve Damage)
  - Atherosclerosis (Hardening of the Arteries)
- Support groups available and Psychosocial needs
- Foot Care
- Insulin teaching (if applicable)
- Financial Assistance with FMH and/or Drug and Supply Companies (if needed)

A session with the Registered Dietitian will also be scheduled to meet all your meal planning and nutritional needs.

Participant Self-Assessment of Diabetes Management

Name: _____

Date: _____

Date of Birth: ___/___/___ Age: _____ Gender: ❑ F ❑ M

Ethnic Background: ❑ White/Caucasian ❑ Black/African American ❑ Hispanic ❑ Native American ❑ Middle-eastern

What is your language preference: ❑ English Other_____

Address: _____

Street City ST Zip

Phone: Home (____)_____Work: (____)_____Mobile: (____)_____

1. What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ Pre-diabetes ❑ GDM ❑ Don't Know

2. Year/Age of Diabetes Diagnoses:_____/_____
   List relatives with diabetes: _____

3. Do you take diabetes medications? ❑ Y (check all that apply below) ❑ N
   ❑ Diabetes pills ❑ Insulin injections ❑ Other
   ❑ Symlin injections ❑ Combination of pills and injections
   About how often do you miss taking your medication as prescribed? _____

4. Do you have other health problems? ❑ Y ❑ N
   Please list other conditions: _____

5. Do you take other medications? ❑ Y ❑ N
   Please list other medications:_____
   _____

6. What is the last grade of school you have completed? _____

7. Are you currently employed? ❑ Y ❑ N
   What is your occupation? _____

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8. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
How many people live in your household? _____

9. How are they related to you? _____

10. From whom do you get support for your diabetes? ❑ Family ❑ Co-workers
❑ Health care providers ❑ Support group ❑ No one

11. Do you have a meal plan for diabetes? ❑ Y ❑ N
If yes, please describe: _____

_____

About how often do you use this meal plan? ❑ Never ❑ Seldom ❑ Sometimes
❑ Usually ❑ Always
Do you read and use food labels? ❑ Y ❑ N
Do you have any diet restrictions: ❑ Salt ❑ Fat ❑ Fluid ❑ None ❑ Other _____
Give a sample of your meals for a typical day:
Time: _____ Breakfast: _____
Time: _____ Lunch: _____
Time: _____ Dinner: _____
Time: _____ Snack: _____
Time: _____ Snack: _____

12. Do you: do your own food shopping? ❑ Y ❑ N Cook your own meals? ❑ Y ❑ N
How often do you eat out? _____

13. Do you drink alcohol? ❑ Y ❑ N Type: _____
How many per day_____ per week_____ occasionally _____
Do you use tobacco: ❑ cigarette ❑ pipe ❑ cigar ❑ chewing ❑ none
❑ quit—how long ago _____

14. Do you exercise regularly? ❑ Y ❑ N Type: _____
How Often:_____
My exercise routine is: ❑ easy ❑ moderately intense ❑ very difficult ❑ intense

15. Do you test check your blood sugars? ❑ Y ❑ N
Blood sugar range: _____ to _____
How often: ❑ Once a day ❑ 2 or more/day ❑ 1 or more/Week ❑ Occasionally
When: ❑ Before breakfast ❑ 2 hours after meals ❑ Before bedtime
What is your target blood sugar range?_____ _____

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