Addressograph Area

INITIAL ASSESSMENT
DIABETES CENTRE

Shading indicates optional completion when recorded elsewhere; e.g., Flow Sheet, Medication Sheet, etc.

Date: _____

Referring/family physician(s):

_____

Accompanied by: ❑ no one ❑ spouse ❑ friend ❑ other: _____

Reason for referral: ❑ newly diagnosed (dx) (≤ 12 mos) ❑ pre-conception counseling
❑ not newly dx (> 12 mos); new to program

DIABETES-RELATED INFORMATION

Year of dx (age at onset): _____ Current age: _____

Previous diabetes education: ❑ N ❑ Y Where/when: _____

Family History (parents, siblings, children)

Diabetes: ❑ Type 1 ❑ Type 2

❑ Hypertension

❑ Obesity

❑ CVD

_____ ❑ **none**

❑ **INSTRUCTED (see Education Checklist)**

HEALTH STATUS

Medications (Non-DM – Include OTC and supplements) ❑ ***see Medication Sheet*** ❑ **none**

Complaints: (present) ❑ ↑ thirst ❑ ↑ urination ❑ fatigue ❑ wt loss ❑ blurred vision ❑ headache
❑ itchy skin ❑ infections ❑ other: _____ ❑ **none**

Recent illness/hospitalization: _____ ❑ **none**

Medical problems (√ problems only):

❑ hearing: _____ ❑ vision: _____ ❑ ↑ BP: _____

❑ stroke: _____ ❑ CVD: _____ ❑ dyslipidemia: _____

❑ cancer: _____ ❑ thyroid: _____ ❑ arthritis: _____

❑ chronic pain: _____ ❑ respiratory: _____ ❑ GI problems: _____

❑ UTI/bladder infections: _____ ❑ renal impairment: _____

❑ altered peripheral sensation (e.g., feet): _____ ❑ sexual problems: _____

❑ depression: _____ ❑ other: _____ ❑ **none**

Allergies (food; drug; environmental): ❑ N ❑ Y (note): _____

_____ ❑ **none**

HEALTH STATUS (cont)

Women of childbearing age (12-45 years) ❑ **n/a**

Birth control: ❑ N ❑ Y Method: _____

Obstetrical history: _____ ❑ **none**

Pregnancy plan: _____ ❑ **none**

How often do you see the following?

GP: _____ Specialist: _____ Foot care: _____

Eye Specialist: ❑ never ❑ yearly ❑ other: _____ Last appt: _____

Dentist: ❑ never ❑ q6mos ❑ other: _____ Last appt: _____

Other: _____ Last appt: _____

Health services utilized: ❑ VON ❑ CH/PH ❑ HCNS ❑ other: _____ ❑ **none**

Flu vaccination: ❑ N ❑ Y Date: _____

Smoking/chewing tobacco: ❑ N ❑ Y Amount: _____ ❑ Quit: _____

Alcohol: ❑ N ❑ Y Type/amount/freq: _____

Social drugs: ❑ N ❑ Y Type/freq: _____

❑ **INSTRUCTED (see Education Checklist)**

SOCIAL ASSESSMENT

Support person in place: ❑ N ❑ Y Comments: _____

Lives with: ❑ alone ❑ spouse/partner ❑ other: _____

_____

Occupation: _____

Hours of work: ❑ full-time ❑ part-time ❑ shift (hours): _____ ❑ **n/a**

❑ Retired ❑ Homemaker ❑ Other: _____

Drug plan (self/spouse): ❑ Pharmacare ❑ employment plan: _____

❑ Social Assistance ❑ other: _____ ❑ **none**

Do you have any financial concerns? ❑ N ❑ Y _____

Your preferred method of learning: ❑ listening and talking ❑ reading ❑ both ❑ other: _____

Do you have any religious, family, or cultural practices that may influence how you care for your health? _____

_____ ❑ **none**

Stressors (If necessary, explore coping mechanisms, support networks, etc.): _____

_____ ❑ **none**

Do you believe that you have diabetes? ❑ N ❑ Y ❑ Unsure _____

Does having diabetes bother you? (fears, past experiences, etc.): _____

How can we help you? _____ ❑ **not stated**

DIABETES TREATMENT

Exercise (type/frequency):

Aerobic/walking ❑ N ❑ Y _____

Resistance/weights ❑ N ❑ Y _____

Other: ❑ N ❑ Y _____ ❑ **no specific exercise routine**

Recreation/hobbies/work activities (type/frequency): _____

Number of hours a day of screen time (i.e., TV, computer, and/or video games): _____

Barriers to physical activity: _____

❑ **Exercise rating indicated on Flow Sheet** ❑ **INSTRUCTED (see Education Checklist)**

Present Treatment Regime ❑ **n/a**

Type: ❑ Meal Plan only ❑ Meal Plan + OAA ❑ Meal Plan + Insulin ❑ Meal Plan + Insulin + OAA

❑ **See Flow Sheet for Insulin/Oral Anti-Hyperglycemic Agents (OAA) dosage**

	Meal Times						Comments
	Bkfst	a.m.	Lunch	p.m.	Supper	hs	(e.g., changes in activity, insulin adjustment, omits, takes when ill, skips meals, etc.)
Usual							
Weekend/Other							
Type of Insulin/OAA	Dosage						

Total units: _____ *U/kg*: _____

Takes dosage as prescribed: ❑ N ❑ Y _____

Takes daily on a regular schedule: ❑ N ❑ Y _____

_____

Comments (as required):

_____

_____

_____

_____

_____

❑ **INSTRUCTED (see Education Checklist)**

INSULIN ❑ **SYRINGE** ❑ **PEN** ❑ **PUMP** ❑ **n/a**

Prepared by: ❑ self ❑ spouse/partner ❑ other: _____

Appropriate preparation: ❑ N ❑ Y ❑ not observed

Injected by**:** ❑ self ❑ spouse/partner ❑ other: _____

Appropriate injection: ❑ N ❑ Y ❑ not observed

Sites used: ❑ arms ❑ thighs ❑ abdomen

❑ buttocks ❑ other: _____

Appropriate site rotation: ❑ N ❑ Y

Lipodystrophy: ❑ N ❑ Y

Appropriate sharps disposal: ❑ N ❑ Y

Appropriate insulin storage: ❑ N ❑ Y

Special aids used: ❑ N ❑ Y

Aware of insulin action: ❑ N ❑ Y

Adjusts insulin: ❑ N ❑ Y

❑ **INSTRUCTED (see Education Checklist)**

HYPOGLYCEMIA ❑ **n/a**

Symptoms: ❑ shaky ❑ sweaty ❑ weak ❑ dizzy ❑ loss of consciousness

❑ numb/tingling ❑ blurred vision ❑ hunger ❑ palpitations ❑ confused

❑ other: _____ ❑ **none**

Times/frequency: _____

Method of treating: _____ ❑ symptoms not linked to hypoglycemia

Cites reasons for hypoglycemia: ❑ N ❑ Y

Aware of proper treatment: ❑ N ❑ Y

Carries proper treatment: ❑ N ❑ Y

Hypoglycemia unawareness: ❑ N ❑ Y

❑ **INSTRUCTED (see Education Checklist)**

Diabetes ID: ❑ N ❑ Y Type: ❑ bracelet ❑ necklace ❑ wallet card

❑ **INSTRUCTED (see Education Checklist)**

MONITORING

❑ **n/a**

❑ N (reason): _____ ❑ Y (frequency): _____

Meter (type/name): _____ **Ketones** (time/frequency/results): _____

Results based on _____ **days**

	ac Bkfst	pc Bkfst	ac Lunch	pc Lunch	ac Supper	pc Supper	hs
Range							
Usual BG							

Based on: ❑ record book ❑ verbal report ❑ meter memory

Comments (e.g., weekend variations, etc.): _____

BP (value): _____ **Cap. blood glucose** (value/time): _____

❑ **n/a**

By: ❑ self ❑ spouse/partner ❑ other: _____

Appropriate technique: ❑ N ❑ Y ❑ not observed

Appropriate sharps disposal: ❑ N ❑ Y

Appropriate QA testing: ❑ N ❑ Y ❑ n/a

Satisfactory comparison: ❑ N ❑ Y ❑ not done

Appropriate record keeping: ❑ N ❑ Y

Appropriate use of results: ❑ N ❑ Y

Frequency during illness: ❑ glucose _____

❑ ketones _____ ❑ n/a

❑ **INSTRUCTED (see Education Checklist)**

FOOT ASSESSMENT - NURSE ONLY

❑ ***See Foot Risk Assessment Form*** ❑ **INSTRUCTED**

NUTRITION

Weight History

Usual wt: _____

Recent gain or loss (< 6 mos): _____

_____

_____

Goal wt (short/long term): _____

Assessment

Present wt: _____ Ht or Ht^2: _____ WC: _____

BMI: _____ Accept. BW range (lbs/kg): _____

Basal req: _____ Activity factor: _____

based on (wt): ❑ actual ❑ goal ❑ other: _____

Energy req: _____
for: ❑ loss ❑ gain ❑ maintenance

HB equations (BEE):
F = 655 + W (9.6 x Wt kg) + H (1.8 x Ht cm) - A (4.7 x age) M = 66.5 + W (13.7 x Wt kg) + H (5 x Ht cm) - A (6.8 x age)

Hx of previous diets: ❑ N ❑ Y Include outcomes/successes: _____

_____

Problems with: bowels ❑ N ❑ Y _____

chewing/swallowing ❑ N ❑ Y _____

appetite ❑ N ❑ Y _____

Eating response to: boredom ❑ N ❑ Y _____

stress ❑ N ❑ Y _____

Restaurant meals (frequency/type): _____

Diet History

Meal/snack times (note weekend changes): _____ ❑ **see page 3**

Skipped meals: ❑ N ❑ Y Freq/times: _____

Food prepared by: ❑ self ❑ spouse/partner ❑ other: _____

Grocery shopping: ❑ self ❑ spouse/partner ❑ other: _____

Cooking methods (times/week): ❑ fry/deep fry _____ ❑ bake/broil/braise/microwave _____

Sodium/salt: ❑ adds to foods ❑ adds in cooking ❑ does not use

Sugar: ❑ adds to foods ❑ adds in cooking ❑ does not use

Diet/special foods: ❑ sweetener _____ ❑ diet drinks _____ ❑ other _____

Recent changes in diet: ❑ ↓ fats ❑ ↓ simple sugars ❑ ↓ portions ❑ ↑ regular meals
❑ ↑ fibre ❑ other: _____ ❑ **none**

Food Record Attached ❑ N ❑ Y

Record Usual/24-hour intake (if necessary)

Common Foods (type/amount/frequency)

Fat:

margarine/butter _____

oil/salad dressing _____

processed meats _____

snack foods (chips) _____

skin/fat on meat _____

gravies/sauces _____

eggs _____

NUTRITION (cont)

Common Foods (type/amount/frequency)

Fibre:

w/g bread/cereals/pasta _____

salads/slaw _____

fruits/vegs _____

dried peas/beans _____

Calcium:

milk _____

cheese _____

yogurt _____

Sugar/sweets:

soft drinks (regular) _____

jams/jellies/syrups _____

cakes/pies/squares/cookies _____

candy/bars _____

ice cream/frozen yogurt _____

muffins/donuts _____

Other:

mixed dishes _____

condiments _____

fruit juices _____

tea/coffee _____

water _____

Food dislikes:

Problem Areas Identified ❑ **none**

❑ meal spacing ❑ meal irregularity ❑ unnecessary snacks ❑ high fat

❑ poor meal balance ❑ inadequate fibre ❑ high simple sugar ❑ high Na

❑ variable CHO intake ❑ CHO loading ❑ excessive calories ❑ excessive protein

❑ nutritionally inadequate food group: ❑ milk ❑ fruit ❑ veg. ❑ protein ❑ starch

❑ excessive caffeine ❑ inadequate fluids ❑ other: _____

Education/ Material Given: ❑ Canada's Food Guide ❑ Diabetes Food Guide ❑ Beyond the Basics™

❑ Just the Basics™ ❑ CHO Counting ❑ Sample Menu

❑ Glycemic Index ❑ other: _____

❑ **See DCPNS Meal Plan Sheet**

Additional Modifications: ❑ fat ❑ sodium ❑ fibre ❑ protein ❑ other: _____

❑ **INSTRUCTED (see Education Checklist)**

Addressograph Area

TO BE COMPLETED BY THE TEAM
Written contributions to this plan by persons other than those indicated at the bottom of this page should be signed.

Considerations for Care Planning Identified:

❑ Method of learning: _____

❑ Special learning needs (e.g., literacy, language, etc.): _____

❑ Religious, family, or cultural influences: _____

❑ Barriers to attending follow up (e.g., transportation, time, etc.): _____

Problem Areas Identified:

❑ Nutrition ❑ Exercise/Activity ❑ Insulin/Medication ❑ Monitoring ❑ Smoking

❑ Alcohol ❑ Financial concerns/Access to supplies ❑ Insufficient support and/or stressors

❑ Personal beliefs/Non acceptance ❑ Other: _____

Comments: _____

_____

Patient Priorities: _____

_____

Follow up: ❑ Individual instruction ❑ Group instruction ❑ Weight check only

❑ Other: _____ Date: _____

Referral: ❑ Social Work/Psychology ❑ Eye specialist ❑ Foot care services ❑ HCNS/VON

❑ Other: _____ ❑ **none**

Date	Name (Print)	Signature	Initials	Discipline

Nondiscipline-specific portions of the initial assessment form were completed by: ❑ PDt ❑ RN

❑ Other _____