Addressograph Area

PREDIABETES INITIAL ASSESSMENT

DIABETES CENTRE

Shading indicates optional completion if recorded elsewhere; i.e., Flow Sheet, Medication Sheet, etc.

Date: _____

Referring/family physician(s):

_____

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

FAMILY HISTORY (parents, siblings, children)

Diabetes: ❑ Type 1 ❑ Type 2 _____

Prediabetes: ❑ IFG ❑ IGT ❑ IFG & IGT _____

❑ Cardiovascular Disease (CVD) _____

❑ Obesity ❑ Hypertension _____ ❑ **none**

HEALTH STATUS

Medications (Include OTC and supplements) ❑ **see Medication Sheet** ❑ **none**

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

Medical problems (√ problems only):

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

❑ CVD: _____ ❑ stroke: _____ ❑ thyroid: _____ ❑ cancer: _____

❑ kidney/urinary tract: _____ ❑ bladder: _____ ❑ bowel: _____

❑ arthritis: _____ ❑ chronic pain: _____ ❑ depression (dx/tx): _____

❑ previous diagnosis of GDM: _____ ❑ other: _____ ❑ **none**

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

_____ ❑ **none**

How often do you see the following?

GP: _____ Specialist: _____

Other: _____ Last appt: _____

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

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

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

HEALTH STATUS (cont)

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

Birth control: ❑ N ❑ Y Method: _____

Pregnancy plan: _____ ❑ **none**

❑ **INSTRUCTED**

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**

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

_____

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

PHYSICAL ACTIVITY (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: _____

❑ **Indicate exercise rating on Flow Sheet** ❑ **INSTRUCTED**

NUTRITION

Weight History

Usual wt: _____

Recent gain or loss (< 6 mos): _____

_____

_____

Goal wt (short/long term): _____

Assessment

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

BMI: _____ WC: _____

Acceptable BW range (lbs/kg): _____

_____

_____

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): _____

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

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

Nutrition/ Food Record ❑ **See Questionnaire**

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

❑ other _____

Education/ Material Given: ❑ Canada's Food Guide ❑ Sample Menu
❑ Just the Basics ❑ other: _____

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

❑ **INSTRUCTED (see Education Checklist)**

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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 ❑ Smoking ❑ Alcohol ❑ Financial concerns

❑ Insufficient supports and/or stressors ❑ Other: _____

Comments: _____

_____

Patient Priorities: _____

_____

Follow up: ❑ Prediabetes (Lifestyle change class) ❑ Group instruction ❑ Weight check only ❑ Annual follow-up

❑ Other: _____ Date: _____

Date	Name (Print)	Signature	Initials	Discipline

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

❑ Other _____