Addressograph Area

PREGNANCY INITIAL ASSESSMENT
DIABETES CENTRE

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

For sections where information has already been collected on the Adult Initial Assessment Form, check (√) "see Adult Initial Assessment."

Date: ____________ Referring/family physician(s): ____________

Accompanied by: ❑ no one ❑ spouse/partner ❑ friend ❑ other: ____________

DIABETES-RELATED INFORMATION

Weeks gestation at time of first visit: ____________

Pre-existing: ❑ Type 1 ❑ Type 2 ❑ IFG ❑ IGT ❑ IFG/IGT Age at onset: ____________

Current: ❑ GDM ❑ IGT of Pregnancy Weeks gestation at time of diagnosis: ____________

50 g Oral Glucose Screen: Date:	**75 g OGTT:** Date:
1 hour: ____________	1 hour: ________ 2 hour: ________

❑ Previous GDM/IGT of Pregnancy (circle) When: ____________

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)**

What concerns/questions do you have about diabetes and pregnancy? ____________

____________ ❑ **none**

HEALTH STATUS

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

____

Recent illness/hospitalization: ____________

____________ ❑ **none**

Medical problems (include present pregnancy problems; e.g., placenta previa, UTIs, PIH, etc.):

❑ Thyroid ❑ Hypertension ❑ GI Problems ❑ Other: ____________

____________ ❑ **none**

Allergies (food, drug, environmental): ❑ N ❑ Y (note): ____________

____________ ❑ **none**

HEALTH STATUS (cont)

Pregnancy-Specific Information

❑ *See attached NS Prenatal Record--**Do not complete***

LNMP: ______________ EDD: ______________ Wks gestation: ________________ Multiples: ❑ N ❑ Y

Gravida: ______________ Para: ______________ Abort: __________ SB: ________ NND: ________________

Previous pregnancy complications (anomalies, UTIs, PIH, C-section, large babies, etc.):

____

____ ❑ **none**

Did you receive preconception counseling? ❑ N ❑ Y (when/where): ________________________________

Did you take folic acid prior to pregnancy? ❑ N ❑ Y ____

Present symptoms/concerns: ❑ ↑ thirst ❑ ↑ urination ❑ blurred vision ❑ headache

❑ nausea ❑ vomiting ❑ wt loss ❑ edema ❑ fatigue ❑ heartburn

❑ other: ____ ❑ **none**

How often do you see the following?

GP: ________________________________ Obstetrician: ________________________________

Endocrinologist/Specialist: ____ Last appt: __________

Eye Specialist: ❑ never ❑ yearly ❑ other: ________________ Last appt: __________

Dentist: ❑ never ❑ q6mos ❑ other: ________________ Last appt: __________

Other: ____ Last appt: __________

Attending prenatal classes: ❑ N ❑ Y Where/when: ____

Planning to breastfeed: ❑ N ❑ Y If not, reason: ____

Smoking: ❑ N ❑ Y Amount: ______________ ❑ Quit (when): ______________________________

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

Social drugs: ❑ N ❑ Y Type/freq: ____

❑ **INSTRUCTED (see Education Checklist)**

SOCIAL ASSESSMENT

❑ **see Adult Initial 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? __________

____

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

____ ❑ **none**

DIABETES TREATMENT

Exercise (type/frequency): ❑ **Restricted (why):** ________________

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: ________________

❑ **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 insulin units: ________ *U/kg*: ________

Self-adjusts: ❑ N ❑ Y

Takes dosage as prescribed: ❑ N ❑ Y ________________

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

❑ **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 ________________

INSULIN (cont)

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 ______________________

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

❑ INSTRUCTED (see Education Checklist)

MONITORING

❑ n/a

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

Meter (name): ______________________

Ketones (time/frequency/results): ______________________ **❑ Blood** **❑ Urine**

Results based on ________ **days**

	ac Bkfst	**pc Bkfst** (1 or 2 hrs)	**ac Lunch**	**pc Lunch** (1 or 2 hrs)	**ac Supper**	**pc Supper** (1 or 2 hrs)	**hs**
Range							
Usual BG							

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

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

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 ______________________

MONITORING (cont)

Appropriate record keeping: ❑ N ❑ Y ______

Appropriate use of results: ❑ N ❑ Y ______

Frequency during illness: ❑ glucose ______

❑ ketones ______ ❑ n/a ______

Meter given: ❑ N ❑ Y ______

❑ INSTRUCTED (see Education Checklist)

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

NUTRITION

Weight History

Present wt: ______ Ht: ______

Prepreg. wt: ______

Prepreg. usual wt: ______

Prepreg. goal wt: ______

Wt gain in previous pregnancies: ______

______

Comments: ______

______

Assessment

Age: ______ Wt chg/wks gest.: ______

Prepregnancy BMI: ______

❑ uw (<20) ❑ acc (20-25-27) ❑ ow (>27) ❑ ob (>29)

Nonpreg. acceptable BMI wt range (lbs/kg): ______

Recommended wt gain to date: ______

❑ uw ❑ acc ❑ ow ❑ ob **❑ see graph**

Desirable rate of gain for remainder of preg: ______

For a target total gain of: ______

Energy req: ______ Based on (lbs or kg): ❑ usual wt ❑ goal wt ❑ other: ______

HB equations (BEE): F = 655 + W (9.6 x Wt kg) + H (1.8 x Ht cm) - A (4.7 x age) Activity factor: ______

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 History (cont)

Diet/special foods: ❑ sweetener ______________ ❑ diet drinks ______________ ❑ other ______________________

Recent changes in diet: ❑ ↓ simple sugars ❑ ↓ fats ❑ ↓ portions ❑ ↑ regular meals ❑ add snacks

❑ ↑ fibre ❑ other: ____ ❑ **none**

Food Record Attached ❑ N ❑ Y

Record Usual/24 hour intake (if necessary)

	CH0	PR0	FAT

Food Dislikes:

Common Foods (type/amount/frequency)

Grains:
w/g bread/cereals ______________________
rice/potato/pasta ______________________

Vegs/Fruits
salads/slaw ______________________
fruit (whole) ______________________
vegetables ______________________
fruit juice ______________________

Milk Group:
milk ______________________
cheese ______________________
yogurt ______________________
other: ______________________

Meats and Alternatives
meat/fish/poultry ______________________
eggs ______________________
peanut butter ______________________
beans/lentils ______________________
tofu ______________________

Other:
mixed dishes ______________________
tea/coffee ______________________
diet pop ______________________
water ______________________
____
____

Fat:
margarine/butter ______________________
oil/salad dressing ______________________
other: ______________________

Sugar/sweets:
soft drinks (regular) ______________________
jams/jellies/syrups ______________________
cakes/pies/squares ______________________
candy/bars ______________________
ice cream/f. yogurt ______________________
other: ______________________

NUTRITION (cont)

Problem Areas Identified: ❑ **none**

❑ meal spacing ❑ meal irregularity ❑ inadequate 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 ______________________________

❑ inadequate vit/minerals: ❑ calcium ❑ iron ❑ Vit C ❑ folic acid

❑ inappropriate/inadequate supplement: ______________________________

❑ 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 supports 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 ______