RE-REFERRAL ASSESSMENT

DIABETES CENTRE (DC)

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

Unit No
Name
Address
Sex D.O.B.
HC No.
Phone number: (h) ____________
(w) ____________

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

Type of diabetes: ❑ Type 1 ❑ Type 2 ❑ Prediabetes ❑ Other: ____________

Date of diagnosis: ____________ Date of last DC appt: ____________

Reason for re-referral: ____________

How can we help you? ____________

Accompanied by: ____________

DIABETES-RELATED INFORMATION

Complaints: (present) ❑ ↑ thirst ❑ ↑ urination ❑ fatigue ❑ wt. loss ❑ blurred vision ❑ headache
❑ other: ____________ ❑ **none**

HEALTH STATUS

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

Medical problems since last DC visit (hospitalizations, new diagnosis, etc.): ____________

____

____

____________ ❑ **none**

Medical problems: (√ problems only)
❑ hearing ❑ vision ❑ ↑ BP ❑ stroke ❑ cardiovascular disease ❑ dyslipidemia
❑ respiratory ❑ UTI/bladder infections ❑ renal impairment ❑ GI problems
❑ thyroid ❑ arthritis ❑ cancer ❑ sexual problems ❑ depression (dx/tx)
❑ altered peripheral sensation (e.g., feet) ❑ chronic pain
❑ other: ____________ ❑ **none**

Allergies (food; drugs; environmental): ❑ N ❑ Y (note) ____________

____________ ❑ **none**

Smoking/chewing tobacco: ❑ N ❑ Y Amount: ____________ ❑ quit: ____________

Alcohol: ❑ N ❑ Y Amount: ____________ ❑ with food: ____________

Social drugs: ❑ N ❑ Y Type/frequency: ____________

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

Birth control: ❑ N ❑ Y Method: ____________

Obstetrical history: ____________ ❑ **none**

Pregnancy plan: ____________ ❑ **none**

SOCIAL ASSESSMENT

Recent changes in living/financial arrangements: ❑ N ❑ Y ______________________

Do you have financial concerns? ❑ N ❑ Y ______________________

Do you have a medical/drug plan? ❑ N ❑ Y ______________________

Recent stressors (If necessary, explore coping mechanisms, support networks, etc.): ______________________

____ ❑ **none**

Would you like some additional help in coping? ❑ N ❑ Y ______________________

DIABETES TREATMENT

Physical Activity (type/frequency):

Walking (routine) ❑ N ❑ Y ______________________

Pedometer use ❑ N ❑ Y ______________________

Exercise program ❑ 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 (see 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		Lunch		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 ______________________

❑ *INSTRUCTED (see checklist)*

INSULIN - *NURSE ONLY* ❑ **SYRINGE** ❑ **PEN** ❑ **PUMP** ❑ **n/a**

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

Appropriate preparation: ❑ N ❑ Y ❑ not observed ______

Appropriate injection: ❑ N ❑ Y ❑ not observed ______

Appropriate site rotation: ❑ N ❑ Y ______

Appropriate sharps disposal: ❑ N ❑ Y ______

Appropriate insulin storage: ❑ N ❑ Y ______

Special aids used: ❑ N ❑ Y ______

Adjusts insulin: ❑ N ❑ Y ______

❑ *INSTRUCTED (see checklist)*

HYPOGLYCEMIA

Times/frequency: ______ ❑ **n/a**

Method of treating: ______

Cites reasons for hypoglycemia: ❑ N ❑ Y ______

Aware of proper treatment: ❑ N ❑ Y ______

Carries proper treatment: ❑ N ❑ Y ______

Hypoglycemia unawareness ❑ N ❑ Y ______

❑ *INSTRUCTED (see checklist)*

MONITORING ❑ **n/a**

❑ N (reason): ______

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

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

______

______

MONITORING - *NURSE ONLY* o **n/a**

Appropriate technique: ❑ N ❑ Y ______

Appropriate QA testing: ❑ N ❑ Y ______

MONITORING - *NURSE ONLY (cont)*

Appropriate record keeping: ❑ N ❑ Y ______

Appropriate freq of testing: ❑ N ❑ Y ______

Appropriate use of results: ❑ N ❑ Y ______

Appropriate sharps disposal: ❑ N ❑ Y ______

❑ *INSTRUCTED (see checklist)*

FOOT ASSESSMENT - *NURSE ONLY*

❑ *See Foot Assessment Form*

Foot care practices questionnaire completed: ❑ N ❑ Y ______

Aware of recommended foot care practices: ❑ N ❑ Y ______

❑ *INSTRUCTED*

NUTRITION - *DIETITIAN ONLY*

Weight History

Recent gain or loss (< 6 mos): ______

Problems with: appetite ❑ N ❑ Y
bowels ❑ N ❑ Y
chewing/swallowing ❑ N ❑ Y

Assessment

Present wt: ______ Ht/Ht m^2: ______ WC: ______

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

Basal req.: ______ Activity factor: ______

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

Energy req.: ______
for: ❑ loss ❑ gain ❑ maintenance

Diet History

Meal/snack times: ______ ❑ **see page 2**

❑ as recommended (regular/consistent) ❑ not as recommended (irregular)

Recent changes in diet: ❑ ↓ fats ❑ ↑ fibre ❑ ↑ fruits & veg. ❑ ↓ empty calories ❑ ↓ portions ❑ ↑ regular meals

❑ other: ______ ❑ **none**

Recognized problem areas (pt): ______

______ ❑ **none**

Diet foods/sweeteners: ❑ N ❑ Y ______

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 food (chips) ______

skin/fat on meat ______

gravies/sauces ______

eggs ______

NUTRITION (cont)

Common Foods (type/amount/frequency)

Fiber:

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/f. yog. ______

muffins/donuts ______

Other:

mixed dishes ______

condiments ______

fruit juices ______

tea/coffee ______

water ______

Comprehension of meal planning principles: ❏ good ❏ fair ❏ poor ______

Demonstrates healthy food choices: ❏ N ❏ Y

Problem Area 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: ______

Contributing problems ❏ inactivity ❏ alcohol ❏ hx obesity ❏ lifestyle

❏ other: ______ ❏ **none**

Readiness to change ❏ precontemplation ❏ contemplation ❏ preparation ❏ action ❏ maintenance

Meal Plan Given ❏ Canada's Food Guide ❏ Just the Basics™ ❏ Sample Menu

❏ Beyond the Basics™ ❏ CHO Counting ❏ Glycemic Index

❏ other ______ ❏ **See DCPNS Meal Plan Sheet**

Additional modifications: ❏ fat ❏ sodium ❏ fibre ❏ protein ❏ other: ______

❏ *INSTRUCTED (see checklist)*

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.

Unit No.
Name
Address
Sex D.O.B.
HC No.
Phone number: (h) ____________
(w) ____________

Optional: This page may be photocopied and sent as/with the report to the physician.

OVERALL ASSESSMENT/COMMENTS (IDENTIFY 1 TO 3 PRIORITIES):

____

____

____

____

____

____

TEAM PLAN (indicate mutually agreed upon recommendations/goals):

Meal plan: ____

____

Exercise/activity: ____

____

Insulin/OAAs: ____

____

SMBG monitoring (freq): ____

____

Complications prevention: ____

____

Other: ____

____

TEAM DECISION

Plan: ❏ individual instruction ❏ group instruction

❏ 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 ____________