

DIABETES EDUCATIONAL NEEDS ASSESSMENT
(TO COMPLETE THIS FORM SEE INSTRUCTIONS ON PAGE 4)

DATE OF DIAGNOSIS: _____

FAMILY MEMBERS WITH DIABETES:

- Parents Brother/Sister Grandparents Grandchildren
 Spouse Aunts/Uncles Children

METHOD OF TREATMENT

Do you follow a special diet? Yes No If yes, explain: _____

Is a nutritional assessment done? Yes No Date: _____

DIABETES MEDICATIONS:	DATE	DRUG NAME	DOSAGE/DAY	SIDE EFFECTS
OTHER MEDICATIONS:				

EXERCISE	DATE	YES	NO	TYPE OF ACTIVITY	HOW OFTEN?	HOW LONG DO YOU EXERCISE?

MONITORING

	DATE	YES	NO
Do you check your Blood Sugar at home?			
Would you like to learn?			

Type _____ Frequency _____ Review of Log _____

Average Range of BS:	DATE	LEVEL	DATE	A,C LEVEL
FBS				
RBS				

FACTORS AFFECTING LEARNING

How do you like to learn new information:

- Reading Slides/Movies Doing things Have someone show you
 Listening Talking/asking questions With a group One on One

PATIENT IDENTIFICATION

FACTORS INFLUENCING EDUCATION			
DATE	YES	NO	
			Do you have a family member or friend who helps you with your diabetes?
			Do you want your support person with you? Who?
			Employed?
			Do you smoke? How much?
			Do you drink Alcohol? How much? What kind?
			Stresses Identified
			a. Emotional
			b. Financial
			c. Family
			d. Other, i.e. transportation, indoor plumbing at home
How many people live in your house?			
Who does most of the cooking in your home?			

FACTORS INFLUENCING EDUCATION				
<i>(Check Yes or No and explain if needed.)</i>				
	DATE	YES	NO	
VISION PROBLEMS				
HEARING PROBLEMS				
MOBILITY PROBLEMS				
LOSS OF SENSATION				
COMPLICATIONS OF DM				
ENGLISH PRIMARY LANGUAGE SPOKEN				

HEALTH BELIEFS			
DATE	YES	NO	
			Do you feel Diabetes can be prevented?
			Do you believe your religious/spiritual beliefs affect your health?
			Do you believe that no matter what you do, if you are going to get sick, you will?
Do you feel your health is: <input type="checkbox"/> poor <input type="checkbox"/> good <input type="checkbox"/> excellent Date _____ Weight _____ Do you believe you are: <input type="checkbox"/> too fat <input type="checkbox"/> too thin <input type="checkbox"/> just right What would like to weigh? _____			
How do you feel about having diabetes? <input type="checkbox"/> Angry <input type="checkbox"/> Annoyed <input type="checkbox"/> Afraid <input type="checkbox"/> Depressed <input type="checkbox"/> Guilty <input type="checkbox"/> Satisfied <input type="checkbox"/> Worried <input type="checkbox"/> No Way <input type="checkbox"/> Denial <input type="checkbox"/> Always tired <input type="checkbox"/> Sometimes Tired			
How much energy do you usually have? <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High			

CURRICULUM

Check the topics you feel you need to learn more about so you can control your diabetes.

- | | |
|---|---|
| <input type="checkbox"/> What is Diabetes
<input type="checkbox"/> Feelings about having Diabetes
<input type="checkbox"/> Coping with Diabetes at home
<input type="checkbox"/> Nutrition
<input type="checkbox"/> Exercise
<input type="checkbox"/> Medications
<input type="checkbox"/> Monitoring Blood Glucose
<input type="checkbox"/> Low blood sugar
<input type="checkbox"/> High blood sugar
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Smoking
<input type="checkbox"/> Retinopathy
<input type="checkbox"/> Periodontal Disease
<input type="checkbox"/> Neuropathy | <input type="checkbox"/> Nephropathy
<input type="checkbox"/> Illness
<input type="checkbox"/> Complications
<input type="checkbox"/> Personal Care
<input type="checkbox"/> Responsibilities of care
<input type="checkbox"/> Use of Health Care Systems
<input type="checkbox"/> Community Resources
<input type="checkbox"/> Alcohol and Diabetes
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Foot Care
<input type="checkbox"/> Gestational Diabetes
<input type="checkbox"/> Pre-Preg Counseling
<input type="checkbox"/> Diabetes & Pregnancy
<input type="checkbox"/> Other: |
|---|---|

DATE	IDENTIFIED NEED	PLAN OF ACTION	DATE	EVALUATION/OUTCOME

PATIENT IDENTIFICATION

DATE	REFERRALS	DATE OF FOLLOW-UP	PROVIDER SIGNATURE	INITIALS

INSTRUCTIONS

The Diabetes Patient Educational Needs Assessment form (IHS-504) will be filed in the "Diabetes" section (IHS-677-1) of the patient's chart. This assessment form can be filled out by both the health care providers and/or the patient. The assessment form can be completed during one clinic visit or over a period of several clinic visits. The needs assessment should be upgraded yearly or as needed.

The following is a list of abbreviations that are used in the form:

- BS = Blood Sugar
- FBS = Fasting Blood Sugar
- RBS = Random Blood Sugar
- A C = Glycosylated Hemoglobin Test