

Diabetes Self-Management Training (DSMT) - 3 Month Follow-up

	Physician's Name:	Phone	Address
Name (Last) _____ (First) _____ (M.I.) _____	__FP/GP__Ped__Int__Endo__Other	_____	_____ _____
<input type="checkbox"/> 1:1 <input type="checkbox"/> Phone <input type="checkbox"/> Letter <i>or</i> <input type="checkbox"/> Dropped-out <input type="checkbox"/> Refused <input type="checkbox"/> Unable to Contact <input type="checkbox"/> Moved <input type="checkbox"/> Deceased			
Clinical Data Since Last Encounter (If Applicable)			
Weight (lbs) _____ Blood Pressure _____ / _____ HbA1c _____ Range _____ — _____ Date _____ Lipid Profile Date _____ Total Cholesterol _____ HDL-C _____ LDL-C _____ Triglycerides _____	Annual Microalbumin Screen <input type="checkbox"/> Proteinuria Present <input type="checkbox"/> Proteinuria Absent/Screen done _____ Screen Result _____ Date Screen Test Used: <input type="checkbox"/> Albumin-to-Creatinine Ratio (Spot) <input type="checkbox"/> 24-hour Collection <input type="checkbox"/> Timed Collection (eg. 4 hr or Overnight)		
Content Area Knowledge Rating	R a t i n g	Behavioral Assessment/ Current Practice	
1 = No 2 = Little 3 = Basic 4 = Advanced 5 = Comprehensive			
1. Diabetes disease process/treatment options			
2. Physical activity			
3. Medications			
4. Monitoring			
5. Preventing, detecting, and treating acute complications			
6. Preventing (risk reduction), detecting, and treating chronic complications			
7. Goal-setting and problem solving			
8. Psychosocial adjustment			
9. Preconception care, pregnancy, and gestational diabetes management			
10. Nutritional management			
Plan of Care:			
Time Spent: _____ Minutes			

_____ / _____
 Date of Next Follow-up

_____ / _____
 Signature of Participant / Date

_____ / _____
 Signature of Instructor / Date