Maine Diabetes Prevention and Control Program
Diabetes Self-Management Training (DSMT/1)
Preassessment – Page 1

Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone	Address

Name Record participant's name.

Physician Enter the name of the physician who referred the participant to your DSMT Program. Indicate, with a check (√) to the left, the specialty of the physician: **FP/GP** (family practice/general practice); **Ped** (pediatrician); **Int** (internist); **Endo** (endocrinologist); or **Other.**

Address Record participant's mailing address. Blacken out the information on the DPCP copy.

Phone # Record the participant's home phone number.

Race ☐ American Indian or Alaskan Native, ☐ Asian, ☐ Black or African-American, ☐ Native Hawaiian or Pacific Islander,
☐ White (Includes Arabs and other Middle Eastern Cultures), ☐ Some Other Race ________________________,
☐ Two or More Races ________________________________.
Ethnic ☐ Hispanic or Latino, ☐ Non-Hispanic or Latino

Date of Birth __________ Lipid Profile Date ________________ Occupation_________________________
Gender M___ F____ Total Cholesterol _________________ Education _________________________
Height (Inches) _________ HDL-C __________ LDL-C ________ Health Insurance
Weight (lbs) _________ Triglycerides ____________________ ☐ Medicare ☐ MaineCare
Blood Pressure _____/____ Annual Microalbumin Screen ☐ Commercial ☐ No Insurance
__ Proteinuria Present Learning Style ______________________
Year of Onset ___________ __ Proteinuria Absent/Screen done Challenges _________________________
Screen Result __________________ Cultural Considerations ________________
HbA1c ________________ Date ___________________________
Range ______ --- ______ Screen Test Used: Immunizations
Date ________________ ___Albumin-to-Creatinine Ratio (Spot) __ Influenza Vaccine in past year
___24 hour Collection __Pneumococcal Vaccine
___Timed Collection (e.g. 4hr of Overnight)

Immunizations
Date ___Albumin-to-Creatinine Ratio (Spot) __ Influenza Vaccine in past year
___24 ___24 hour Collection __Pneumococcal Vaccine
___Timed Collection (e.g. 4hr of Overnight)

Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African-American – A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander – A person having origins of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White – A person having origins in any of the original people of Europe, the Middle East, or North Africa. Including Italian, Lebanese, Near Easterner, Arab, or Polish.

Some Other Race – Includes all other persons not included in the "White," "Black," "American Indian, Eskimo, or Aleut," and the "Asian," or "Pacific Islander" race categories describes above. Persons reporting in the "Some Other Race" category and providing write-in entries such as multiracial, multiethnic, mixed, interracial, Wesort, or a Spanish/Hispanic origin group. Write in the participant's response in the area provided on the form.

Two or More Races – People may choose to provide two or more races. Write in the participant's response in the area provided on the form.

Ethnic - Check (√) the participant's ethnic category **Hispanic or Latino,** or **Non-Hispanic or Latino.** Note: persons of Hispanic or Latino origin may be of any race.

Race ☐ American Indian or Alaskan Native, ☐ Asian, ☐ Black or African-American, ☐ Native Hawaiian or Pacific Islander, ☐ White (Includes Arabs and other Middle Eastern Cultures), ☐ Some Other Race ________________________, ☐ Two or More Races ________________________.

☐ Non-Hispanic or Latino

Date of Birth ____________
Sex M_____ F ___
Height (Inches) ____________
Weight (lbs) ____________
Blood Pressure _______/ ____

Year of Onset ____________

HbA1c ________________
Range ________ --- _______
Date ________________

Lipid Profile Date _______________
Total Cholesterol ________________
HDL-C __________ LDL-C ________
Triglycerides ___________________
Annual Microalbumin Screen
__ Proteinuria Present
__ Proteinuria Absent/Screen done
Screen Result _______________
Date _________________________
Screen Test Used:
___Albumin-to-Creatinine Ratio (Spot)
___24 hour Collection
___Timed Collection(e.g. 4hr of Overnight)

Occupation________________________
Education ________________________
Health Insurance
☐ Medicare ☐ MaineCare
☐ Commercial ☐ No Insurance
Learning Style ____________________
Challenges ________________________
Cultural Considerations ______________
Immunizations
__ Influenza Vaccine in past year
__Pneumococcal Vaccine

Date of Birth Enter the participant's date of birth, including month, day and year.

Sex Check(√) either **M** for Male, or **F** for Female.

Height Record participant's height in inches, (i.e. if client is 5'8", record 68"). See listing of Conversions from "Feet and Inches" to "Inches" in DSMT Program Manual.

Weight Record participant's weight in pounds (lbs).

Blood Pressure Measure and record the blood pressure reading, (i.e. 120/72).

Year of Onset Record the year the participant was diagnosed with diabetes.

Note: *For the following data items, laboratory values for HbA1c, Lipid Profile and Microalbuminuria may be self-reported or come from the physician's referral form.*

- *Record "NA" (not available) if the participant self-reports that the test was performed, but no values were reported by the participant or referring physician.*

HbA1c Record the most recent Hemoglobin A1c (HbA1c) value measured within the past year.

Range of Lab Record the normal HbA1c range for the laboratory that processed the participant's blood sample.

Date of HbA1c Record the month and year the HbA1c was measured.

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☐ White (Includes Arabs and other Middle Eastern Cultures), ☐ Some Other Race ________________________,
☐ Two or More Races ________________________________.
Ethnic ☐ Hispanic or Latino,
Date of Birth __________
Gender M___ F____
Height (Inches) _________
Weight (lbs) _________
Blood Pressure _____/____

Year of Onset ___________

HbA1c ________________
Range ______ --- ______
Date ________________

Lipid Profile Date _____________
Total Cholesterol _____________
HDL-C _______ LDL-C _______
Triglycerides ________________
Annual Microalbumin Screen
__ Proteinuria Present
__ Proteinuria Absent/Screen done
Screen Result ______________
Date ____________________
Screen Test Used:
__Albumin-to-Creatinine Ratio (Spot)
__24-hour Collection
__Timed Collection (e.g. 4hr or Overnight)

ation________________________
ion ________________________
Insurance
licare ☐ MaineCare
nmercial ☐ No Insurance
g Style ______________________
ges ________________________
l Considerations ______________

izations
__ Influenza Vaccine in past year
__Pneumococcal Vaccine

Lipid Profile Date Record the month and year when the most recent lipid profile (Total Cholesterol, HDL, LDL, Triglycerides) was measured within the past year.

Total Cholesterol Record the Total Cholesterol value measured.

HDL-C Record the high-density lipoprotein (HDL-C) value measured.

LDL-C Record the low-density lipoprotein (LDL-C) value measured.

Triglycerides Record the Triglycerides value measured.

Annual Microalbumin Screen

Proteinuria Present Check (√) if participant has proteinuria, and a microalbuminuria screen was not done.

Proteinuria Absent Check (√) if participant does not have proteinuria, and a microalbuminuria screen was done.

Screen Result Record the most recent microalbumin value measured within the past year.

Date of Screen Record the month and year the microalbumin was measured.

Screen Test Used Check (√) the microalbumin screen test used: (**Albumin-to-Creatinine Ratio** (Spot), **24-hour Collection**, or **Timed Collection** (e.g. 4 hr or Overnight).

Race ☐ American Indian or Alaskan Native, ☐ Asian, ☐ Black or African-American, ☐ Native Hawaiian or Pacific Islander, ☐ White (Includes Arabs and other Middle Eastern Cultures), ☐ Some Other Race ________________________,
☐ Two or More Races ________________________________.

Ethnic ☐ Hispanic or Latino, ☐ Non-Hispanic or Latino

Date of Birth __________
Gender M___ F____
Height (Inches) _________
Weight (lbs) _________
Blood Pressure _____/____

Year of Onset ___________

HbA1c ________________
Range ______ --- ______
Date ________________

Lipid Profile Date ________________
Total Cholesterol _________________
HDL-C __________ LDL-C ________
Triglycerides ____________________
Annual Microalbumin Screen
__ Proteinuria Present
__ Proteinuria Absent/Screen done
Screen Result __________________
Date __________________________
Screen Test Used:
___Albumin-to-Creatinine Ratio (Spot)
___24 hour Collection
___Timed Collection(e.g. 4hr of Overnight)

Occupation ________________
Education _________________
Health Insurance
☐ Medicare ☐ MaineCare ☐
Commercial ☐ No Insurance Learning
Style _____________
Challenges ________________
Cultural Considerations ______

Immunizations
_Influenza Vaccine in past year
_Pneumococcal Vaccine

Occupation	Record the participant's occupation. Please be as specific as possible (e.g. "Welder" rather than "Bath Iron Works")
Education	Record the number of years of formal education the participant completed, (i.e. if the participant attended school through the ninth (9th) grade, record "9" on the appropriate line.)
Health Insurance	Record participant's primary source of health insurance (MaineCare, Medicare, or Commercial). If the participant is not insured, record "no insurance."
Learning Style	Describe the learning style of the participant (i.e. visual, auditory, print, experiential).
Challenges	Describe any challenges that may affect participant's learning ability (i.e. visual impairment, hearing impairment, literacy considerations, language barriers, motor problems, attention deficit, processing difficulties).
Cultural Considerations	Describe any ethnic or cultural influences reported by the participant.
Immunizations	Check (√) if participant had Influenza Vaccine in the past year. Check (√) if participant ever had a Pneumococcal Vaccine.

Type/Management of Diabetes

Type/Management of Diabetes
List medications/medical nutrition therapy as appropriate.

- ☐ Type 1 ____
- ☐ Type 2 – Diet and Exercise Only ________________________
- ☐ Type 2 – Oral Agent(s):
  - ☐ Monotherapy _______________________________
  - ☐ Combination Therapy ________________________
- ☐ Type 2 – Insulin ___________________________________
- ☐ Type 2 – Insulin & Oral(s)
- ☐ Other Type: ____

Specify Management

Type

Circle the participant's type of diabetes and management method. If "**Other Type** " is indicated, please specify. Record on the line to the right medications and nutritional therapy used to treat their diabetes upon referral:

Example: ***"Type 1*** *–* *Rapid-acting insulin before meals glargine at bedtime"*

"Type 2 - Oral Agent(s) *-* *Metformin 250 mg BID"*

"Type 2 - Diet and Exercise Only –
carbohydrate counting or 1500 kcal exchange meal plan.

Health Care Visits in Past Year

Health Care Visits in Past Year
Record number of visits with a provider as appropriate

____ Dilated Eye Exam
Date of last exam ________________
____ Dentist
____ Podiatrist
____ OB/GYN
____ Mental Health Professional
____ Urologist
____ Doctor Visit
____ Emergency Room Visit
Hospital Admissions:
____ Any Cause ____ DM-Related ____ DKA/HHNS

Note: *Record the number of times in the past year that the participant has visited each type of health care provider/facility listed.*

- *Record zero (0) on the appropriate line if the participant has NOT had a visit.*

Dilated Eye Examination	Record the number of times she/he had a dilated eye examination in the past year.
Date of Last Eye Exam	Record the date of the last dilated eye exam.
Dentist	Record the number of times she/he went to a Dentist in the past year.
Podiatrist	Record the number of times she/he went to a Podiatrist in the past year.
OB/GYN	Record the number of times a female participant went to an Obstetrician/Gynecologist in the past year.
Mental Health	Record the number of times she/he went to a Mental Health Professional

Professional in the past year.

Urologist Record the number of times she/he went to a urologist in the past year.

Doctor Visit Record the number of times she/he went to a Doctor for a check-up or illness in the past year.

Emergency Room Visit Record the number she/he went to a hospital Emergency Room in the past year.

Hospital Admissions – In the Past Year

Any Cause Record the total number of times that she/he was admitted overnight to a hospital for **Any Cause** (including diabetes-related) in the past year.

DM-Related Ask this question only if the participant reported she/he was hospitalized for Any Cause (above). Record the number of times she/he was admitted to the hospital overnight for a diabetes (**DM – Related**) cause in the past year.

DKA/HHNS Ask this question only if the participant reported she/he was hospitalized for a DM-Related cause (above). Record the number of times she/he was admitted to the hospital overnight because of diabetic ketoacidosis (**DKA**) or hyperglycemic hyperosmolar non-ketotic syndrome (**HHNS**) in the past year.

Example: Participant reports that he was hospitalized two times in the past year; one time for any cause (Appendicitis) and one time for DKA. This information would be recorded as follows:

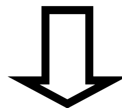
Hospital Admissions:
_2_Any Cause _1_DM-Related _1_DKA/HHNS

Health Status Assessment: Medical Conditions and Treatment ***Check only if applicable. List medication(s)/description as appropriate***	
__ Allergies ___________________________	__ Sexual Dysfunction _____________________________
__ Herbal Supplements _________________	__ Foot Complications _____________________________
__ Tobacco Use ________________________	__Current Deformity/Ulcer _______________________
__ Alcohol Use _________________________	__ Amputation, Lower Extremity (Specify) _________
__ Other substance/product use ___________	__ Monofilament Test Done ________________________
__ Surgery (Any) ________________________	__ Loss of Protective Sensation ______________________
__ Eye Disease __________________________	__ Neuropathy ______________________________________
__ Heart Disease ________________________	__ Other Neurological Disease _______________________
__ Hypertension _________________________	__ Arthritis/Musculoskeletal Disease __________________
__ Hyperlipidemia _______________________	__ Other Endocrine Disease _________________________
__ Peripheral Vascular Disease ____________	__ Cancer ____
__ Respiratory Disease ____________________	__ Mental Health/Psychosocial ______________________
__ Gastrointestinal Disease ________________	__ Recurring Infection ______________________________
__ Pancreatitis/Pancreatic Surgery __________	__ Hx DKA/HHNS ___________________________________
__ Renal Disease _________________________	__ Recurring Hypoglycemia _________________________
__ Genitourinary Disease __________________	__ Planning/Current Pregnant _______________________
	__ Other ____

Health Status Assessment: Medical Conditions and Treatment
Indicate with a check (√) to the left, any conditions noted at the time of referral, record on the line to the right, medications to treat the condition or other details concerning the condition. A written medical diagnosis is not required. If a condition does not exist, leave the line blank.

________________________/____________
Signature of Instructor Date

Signatures
After completing the DSMT Program Preassessment Data Form (DSMT/1), the instructor completing the form signs and dates the form.



Note: Documentation of the DSMT Program Preassessment is continued on DSMT/2.

Maine Diabetes Prevention and Control Program
Diabetes Self-Management Training (DSMT/2)
Preassessment Continued – Page 2

Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone	Address

Name Record participant's name.

Physician Enter the name of the physician who referred the participant to your DSMT Program. Indicate, with a check (√) to the left, the specialty of the physician: **FP/GP** (family practice/general practice); **Ped** (pediatrician); **Int** (internist); **Endo** (endocrinologist); or **Other.**

Address Record participant's mailing address. Blacken out the information on the DPCP copy.

Phone # Record the participant's home phone number.

Content Area Knowledge Rating 1 = No 3 = Basic 5 = Comprehensive 2 = Little 4 = Advanced	Rating	Behavioral Assessment/ Current Practice
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		

Content Area

The Content Area table lists ten areas of diabetes care for which you will evaluate the participant's knowledge, attitudes, behavioral assessment and current practice at the time of referral to the DSMT Program.

Knowledge (1 - 5) On a scale of 1- 5, assess knowledge level of the participant at the time of referral in each content area as follows:

1 = No knowledge
2 = Little knowledge
3 = Basic knowledge
4 = Advanced knowledge
5 = Comprehensive knowledge

Behavioral Assessment/ Current Practice Document Behavioral Assessment and/or Current Practice unique to the participant for each content area. *The knowledge rating will not necessarily reflect current behavior practice.*

Example

Content Area	Knowledge 1 = No 3 = Basic 2 = Little 4 = Advanced 5 = Comprehensive	Behavioral Assessment/ Current Practice
6. Preventing, detecting, and treating acute complications	*3*	*No daily foot checks. Has stopped smoking. Takes medicine for cholesterol and blood pressure every day.*

Outcome 1:1 Meal Planning Session/Individualized Plan of Care

Outcome 1:1 Meal Planning Session/Plan of Care

Outcome of 1:1 Meal Planning Session - Document the outcome of the **1:1 Meal Planning Session** as well as the individualized meal plan developed with participant.

Plan of Care:

Plan of Care - Record the pertinent information concerning the participant's care.

Time Spent: Initial Assessment ____ Minutes 1:1 Meal Planning ____ Minutes

Time Spent - Record the number of minutes spent in each of the following: Record the Initial Assessment, 1:1 Meal Planning

Signature of Participant	Signature of Nurse Instructor/Date	Signature of Dietitian Instructor/Date

Signatures - After completing the DSMT Program Preassessment Data Forms (DSMT/1 and DSMT/2), the participant and instructors completing the form sign and date the form.

Form Distribution

Once the DSMT Program Preassessment Data Forms (DSMT/1 and DSMT/2) are completed, one

photocopy of each form should be made. Please distribute the forms as follows:

Original DSMT/1 and DSMT/2: File in participant's permanent record file (if applicable)

Photocopy of DSMT/1 and DSMT/2: It is recommended one photocopy be given to participant.

Maine Diabetes Prevention and Control Program
Diabetes Self-Management Training (DSMT/3)
Postassessment

____________________ Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone __________	Address __________ __________

Name — Record participant's name.

Physician — Enter the name of the physician who referred the participant to your DSMT Program. Indicate, with a check (√) to the left, the specialty of the physician: **FP/GP** (family practice/general practice); **Ped** (pediatrician); **Int** (internist); **Endo** (endocrinologist); or **Other.**

Address — Record participant's mailing address. Blacken out the information on the DPCP copy.

Phone # — Record the participant's home phone number.

__ 1:1 __ Phone __ Letter OR __Dropped out __ Refused __ Unable to Contact __ Moved __ Deceased

Education Method — Place a check before the method that was used for the postassessment.
______ 1:1 ______Phone _______Letter

Status of Participant — If the participant does not continue with the program, place a check before The description of why the participant has not continued with the program.
_____Dropped out ____Refused ____Unable to Contact ____Moved
_____Deceased

<table>
<tr><td colspan="3">Curriculum Taught</td><td colspan="2">Knowledge Rating
1— No 2— Little 3—Basic 4— Advanced 5 — Comprehensive</td></tr>
<tr><td>_____ 1:1 _____ Group
☐
☐ Special condition exists that contraindicates participation in a group session ie. Language, Hearing, Cognitive, Visual Barriers Assessment</td><td></td><td></td><td>Time Minutes</td><td>Behavioral Assessment/ Current Practice</td></tr>
<tr><td>1. Diabetes disease process/treatment options
1. options</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2. Physical activity</td><td></td><td></td><td></td><td></td></tr>
<tr><td>3. Medications</td><td></td><td></td><td></td><td></td></tr>
<tr><td>4. Monitoring</td><td></td><td></td><td></td><td></td></tr>
<tr><td>5. Preventing, detecting, and treating acute complications
complications</td><td></td><td></td><td></td><td></td></tr>
<tr><td>6. Preventing (risk reduction), detecting, and
treating chronic complications</td><td></td><td></td><td></td><td></td></tr>
<tr><td>7. Goal-setting and problem solving</td><td></td><td></td><td></td><td></td></tr>
<tr><td>8. Psychosocial adjustment</td><td></td><td></td><td></td><td></td></tr>
<tr><td>9. Preconception care, pregnancy, and gestational diabetes management</td><td></td><td></td><td></td><td></td></tr>
<tr><td>10. Nutritional management</td><td></td><td></td><td></td><td></td></tr>
</table>

Curriculum Taught

Note: *The Curriculum Taught table provides a place to document each content area of diabetes education taught.*

___1:1 ___Group — Indicate with a check (√) to the left, whether the participant was taught **exclusively in 1:1 sessions** or in a **Group** class setting.

Special Conditions — Indicate with a check in the box, if special conditions exist that contraindicates participation in a group session, i.e. Language, Hearing, Cognitive, Visual Barriers Assessment

Date — Enter date (month, day, year) the content area was taught.

Initials — Record initials of instructor conducting the class/education.

Time/Minutes — Record the minutes spent in teaching each content area.

Rating (1-5) — On a scale of 1 – 5, assess **knowledge** level of the participant at the time f of postassessment for each content area as follows:
1 = No knowledge
2 = Little knowledge
3 = Basic knowledge
4 = Advanced knowledge
5 = Comprehensive knowledge

Behavioral Assessment/ Current Practice — Document Behavioral Assessment and/or Current Practice information unique to the participant for each content area. *The knowledge rating will not necessarily reflect current behavior practice.*

Example:

Curriculum Taught					
___ 1:1 √ Group □ Special Condition	Date	Initials	Time Minutes	Rating	Behavioral Assessment/ Current Practice
5. Monitoring	1/6/01	J.D.	15	3	Checks blood glucose 4x/day, fasting and pp.

Plan of Care:

Plan of Care — Record other pertinent information concerning the participant's care and/or educational plan for the coming year.

____________________ Date of Next Follow-up	______________/_____ Signature of Participant/Date	____________________ Signature of Instructor/Date

Date of Next Follow-up — Enter date (month, day, year) the participant is scheduled to have her/his next appointment with the DSMT Program Team.

Signatures — After completing the DSMT Program Postassessment (DSMT/3), the participant and instructor completing the form sign and date the form.

Form Distribution

Once the DSMT Program Postassessment Data Form (DSMT/3 is completed, one photocopy of the form should be made. Please distribute the forms as follows:

Original DSMT/3	File in participant's permanent record file.
Photocopy of DSMT/3	It is recommended one photocopy be given to participant.

Maine Diabetes Prevention and Control Program
Diabetes Self-Management Training (DSMT/4)
Behavioral Goals/Plan of Care Form

Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone	Address

Name — Record participant's name.

Physician — Enter the name of the physician who referred the participant to your DSMT Program. Indicate, with a check (√) to the left, the specialty of the physician: **FP/GP** (family practice/general practice); **Ped** (pediatrician); **Int** (internist); **Endo** (endocrinologist); or **Other.**

Address — Record participant's mailing address. Blacken out the information on the DPCP copy.

Phone # — Record the participant's home phone number.

Behavioral Goals/Plan of Care							
				Success Noted			
New Rev Cont	Date	Initials	Behavior Goal	Goal Category	Date	1-3	4-5

Note: The Behavioral Goal Form provides a place to document behavioral goals mutually established by the participant and the instructor.

New Rev Cont — The "New", "Rev" and "Cont" column at the left of the table will indicate the status of the goal.

New — Record "**N**" if this is a newly developed goal.

Revised — Record "**R**" if the goal was set previously and is being revised.

Continued — Record "**C**" if the goal is continued: (i.e. The goal was set previously, was not achieved at a level of 4-5, and needs to be reevaluated.)

Date — Enter date (month, day, and year) when the goal was developed (New, Revised or Continued.)

Initials — Record initials of each instructor conducting the Behavioral Goal Session. Participant may also initial goal-indicating commitment.

Behavioral Goals/Plan of Care							
				Success Noted			
New **R**ev **C**ont	Date	Initials	Behavior Goal	Goal Category	Date	1-3	4-5

Goal Category

1. Exercise	4. General Knowledge	7. Psychological adjustment/stress	9. Blood pressure monitoring
2. Meal Planning	5. Medications	8. Recognize/treat hypo/hyperglycemia	10. Smoking cessation
3. Monitoring	6. Foot care		11. Health care visits
			88. Other

Note: Once the participant and the instructor mutually establish the behavioral goals, the instructor will code the desired goal category:

- *Located below the table are pre-coded "Goal Category" options.*

Behavioral Goal — Record the behavioral goal mutually developed by the participant and the instructor. The goal should be short-term, specific, realistic and measurable. *Example: I will walk to and from the neighbors- approximately 1/4 mile every other day for the next three weeks*. See DSMT Program Manual for detailed information on goal development.

Goal Category — Record the number assigned to the Goal Category that best describes the goal (i.e. Goal Category # 1 is recorded for an exercise goal.)

Success Noted — Record **date** of progress assessment.
On a scale of 1 - 5, assess participant's progress toward each goal as follows:

1 = No attainment
2 = Little attainment
3 = Some attainment
4 = Mostly attained
5 = Always attained

Signature of Participant/Date	Signature of Nurse Instructor/Date	Signature of Dietitian Instructor/Date

Signatures
After completing the DSMT Program Behavioral Goal Form (DSMT/4)), the participant, nurse instructor and dietitian instructor completing the form sign and date the form.

Form Distribution
Once the DSMT Program Behavioral Goal Data Form (DSMT/4) is completed, one photocopy should be made. Please distribute as follows:

Original DSMT/4	File in participant's permanent record file.
Photocopy of DSMT/4	It is recommended one photocopy be given to participant.

Maine Diabetes Prevention and Control Program
Diabetes Self-Management Training (DSMT)

- **Three Month Encounter Form (DSMT 5)**
- **Six Month Encounter Form (DSMT 6)**
- **Encounter Form (DSMT 7)**

Note: The following instructions pertain to DSMT Program Data Forms DSMT/5, DSMT/6 and DSMT/7.

______________________________ Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone ____________	Address ____________________ ____________________

Name Record participant's name.

Physician Enter the name of the physician who referred the participant to your DSMT Program. Indicate, with a check (√) to the left, the specialty of the physician: **FP/GP** (family practice/general practice); **Ped** (pediatrician); **Int** (internist); **Endo** (endocrinologist); or **Other.**

Address Record participant's mailing address. Blacken out the information on the DPCP copy.

Phone # Record the participant's home phone number.

__ 1:1 __ Phone __ Letter <u>0r</u> __ Dropped-out __ Refused __ Unable to Contact __ Moved __ Deceased

1:1
Phone
Letter
or

Indicate with a check (√) to the left, the method used in conducting the follow-up contact: **1:1**, **Phone**, or **Letter**.

Dropped-out
Refused
Unable to Contact
Moved
Deceased

<u>If the follow-up contact was not completed</u>, indicate with a check (√) to the left the reason that the follow-up session was not completed: **Dropped-out, Refused, Unable to Contact, Moved,** or **Deceased.**

Clinical Data Since Last Encounter (If Applicable)	
Weight (lbs) ___________________________	Annual Microalbumin Screen
Blood Pressure __________/ _____________	____ Proteinuria Present
HbA1c ________________________________	____ Proteinuria Absent/Screen done
Range ___________/ __________________	______________________ Screen Result
Date _________________________________	______________________ Date
Lipid Profile Date _______________________	Screen Test Used:
Total Cholesterol ______________________	__ Albumin-to-Creatinine Ratio (Spot)
HDL-C ____________ LDL-C ___________	__ 24-hour Collection
Triglycerides __________________________	__ Timed Collection (e.g. 4 hr or Overnight)

Clinical Data Since Last Encounter (If Applicable)

Weight Record participant's weight in pounds (lbs).

Blood Pressure Measure and record the blood pressure reading.

Note: For the following data items, laboratory values for HbA1c, Lipid Profile and Microalbuminuria may be self-reported or come from the physician's office or lab.

- *Record "NA" (not available) if the participant self-reports that the test was performed, but no values were reported by the participant or referring physician or lab.*

HbA1c Record the most recent HbA1c value measured since the last encounter.

Range of Lab Record the normal HbA1c range for the laboratory that processed the participant's blood sample.

Date of HbA1c Record the month and year the HbA1c was measured.

Lipid Profile Date Record the month/year when the most recent lipid profile (Total Cholesterol, HDL, LDL, Triglycerides) was measured since the last encounter.

Total Cholesterol Record the Total Cholesterol value measured.

HDL-C Record the high-density lipoprotein (HDL-C) value measured.

LDL-C Record the low-density lipoprotein (LDL-C) value measured.

Triglycerides Record the Triglycerides value measured.

Annual Microalbumin Screen

Proteinuria Present Check (√) if participant has proteinuria, and a microalbuminuria screen was not done.

Proteinuria Absent Check (√) if participant does not have proteinuria, and a microalbuminuria screen was done.

Screen Result Record the most recent microalbumin value measured since the last encounter.

Date of Screen Record the month and year the microalbumin was measured.

Screen Test Used Check (√) the microalbumin screen test used: (**Albumin-to-Creatinine Ratio** (Spot), **24-hour Collection**, or **Timed Collection** (e.g. 4 hr or Overnight).

Content Area **Knowledge Rating** 1 = No 3 = Basic 5 = Comprehensive 2 = Little 4 = Advanced	**Rating**	**Behavioral Assessment/** **Current Practice**
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		

Content Area
<u>Note:</u> *The Content Area table lists ten areas of diabetes care for which you will evaluate the participant's knowledge, attitudes, behavioral assessment and current practice since the last encounter.*

Rating (1 - 5)
On a scale of 1 - 5, assess **knowledge** level of the participant since the last encounter in each content area as follows:
1 = No knowledge
2 = Little knowledge
3 = Basic knowledge
4 = Advanced knowledge
5 = Comprehensive knowledge

Behavioral Assessment/ Current Practice
Document Behavioral Assessment and/or Current Practice information unique to the participant for each content area. *The knowledge rating will not necessarily reflect current behavior practice.*

Plan of Care:

Plan of Care
Record other pertinent information concerning the participant's care and/or educational plan to share with team members in the comment section.

Time Spent: __________ Minutes

Time Spent
Record the number of minutes spent in each of the following:
Record the Initial Assessment, 1:1 Meal Planning

____________________ Date of Next Follow-up	____________________/_____ Signature of Participant/Date	____________________/_____ Signature of Instructor/Date

Date of Next Follow-up
Enter date (month, day, year) the participant is scheduled to have her/his next appointment with the DSMT Program Team.

Signatures
After completing the DSMT Program Three Month (DSMT/5), Six Month

(DSMT/6) or Encounter Data Form (DSMT/7), the participant and instructor completing the form sign and date the form.

Form Distribution

Once the ADEF/DSMT Program Three Month, Six Month or Encounter Data Form (DSMT/5, 6, or 7) is completed, one photocopy of the form should be made. Please distribute the forms as follows:

Original DSMT/5, 6 or 7	File in participant's permanent record file.
Photocopy of DSMT/5, 6 or 7	It is recommended one photocopy be given to participant.

Maine Diabetes Prevention and Control Program
Diabetes Self-Management Training (DSMT/8)
One-Year Follow-up - Page 1

________________________________ Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone ____________	Address ________________________ ________________________

Name Record participant's name.

Physician Enter the name of the physician who referred the participant to your DSMT Program. Indicate, with a check (√) to the left, the specialty of the physician: **FP/GP** (family practice/general practice); **Ped** (pediatrician); **Int** (internist); **Endo** (endocrinologist); or **Other.**

Address Record participant's mailing address. Blacken out the information on the DPCP copy.

Phone # Record the participant's home phone number.

_ 1:1 _ Phone _ Letter OR _ Dropped-out _ Refused _ Unable to Contract _ Moved _ Deceased

1:1
Phone
Letter

Indicate with a check (√) to the left, the method used in conducting the follow-up contact: **1:1**, **Phone**, or **Letter**.

or

Dropped-out
Refused
Unable to Contact
Moved
Deceased

If the follow-up contact was not completed, indicate with a check (√) to the left the reason that the follow-up session was not completed: **Dropped-out, Refused, Unable to Contact, Moved,** or **Deceased.**

Clinical Data Since Last Encounter (If Applicable)

Weight (lbs) ___________________________	Annual Microalbumin Screen
Blood Pressure __________/ _____________	____ Proteinuria Present
HbA1c ________________________________	____ Proteinuria Absent/Screen done
Range ___________/ __________________	______________________ Screen Result
Date _________________________________	______________________ Date
Lipid Profile Date ________________________	Screen Test Used:
Total Cholesterol _______________________	__ Albumin-to-Creatinine Ratio (Spot)
HDL-C ____________ LDL-C ___________	__ 24-hour Collection
Triglycerides	Timed Collection (e.g. 4 hr or Overnight)

Clinical Data Since Last Encounter (If Applicable)

Weight Record participant's weight in pounds (lbs).

Blood Pressure Measure and record the blood pressure reading.

Note: For the following data items, laboratory values for HbA1c, Lipid Profile and Microalbuminuria may be self-reported or come from the physician's office or lab.

- *Record "NA" (not available) if the participant self-reports that the test was performed, but no values were reported by the participant or referring physician, or lab.*

HbA1c Record the most recent HbA1c value measured since the last encounter.

Range of Lab Record the normal HbA1c range for the laboratory that processed the participant's blood sample.

Date of HbA1c Record the month and year the HbA1c was measured.

Lipid Profile Date Record the month/year when the most recent lipid profile (Total Cholesterol, HDL, LDL, Triglycerides) was measured since the last encounter.

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Annual Microalbumin Screen

Proteinuria Present Check (√) if participant has proteinuria, and a microalbuminuria screen was not done.

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Screen Result Record the most recent microalbumin value measured since the last encounter.

Date of Screen Record the month and year the microalbumin was measured.

Screen Test Used Check (√) the microalbumin screen test used: (**Albumin-to-Creatinine Ratio** (Spot), **24-hour Collection**, or **Timed Collection** (e.g. 4 hr or Overnight).

Type/Management of Diabetes
List medications/medical nutrition therapy as appropriate.

- ☐ Type 1 ______________________________
- ☐ Type 2 – Diet and Exercise Only ________________________
- ☐ Type 2 – Oral Agent(s):
  - ☐ Monotherapy ______________________________
  - ☐ Combination Therapy __________________________
- ☐ Type 2 – Insulin ______________________________
- ☐ Type 2 – Insulin & Oral(s)
- ☐ Other Type: ______________________________

Specify Management ______________________________

Type/Management of Diabetes

Circle the participant's type of diabetes and management method at the time of the One Year Follow-up. If "**Other Type**" is circled, please specify. Record on the line to the right medications and nutritional therapy used to treat their diabetes upon referral:

Example: ***"Type 1** – Rapid-acting insulin before meals glargine at bedtime"*

***"Type 2 - Oral Agent(s)** - Metformin 250 mg BID"*

"***Type 2 - Diet and Exercise Only** – (carbohydrate counting or 1500 kcal exchange meal plan.)*

Health Care Visits in Past Year (Since the Preassessment Interview)

Health Care Visits in Past Year
Record number of visits with a provider as appropriate

____ Dilated Eye Exam
Date of last exam ___________
____ Dentist
____ Podiatrist
____ OB/GYN
____ Mental Health Professional
____ Urologist
____ Doctor Visit
____ Emergency Room Visit
___Hospital Admissions
Any Cause
DM-Related
DKA/HHNS

Note: Record the total number of times since the preassessment interview that the participant has visited each type of health care provider/facility listed.

- *Record zero (0) on the appropriate line if the participant has NOT had a visit.*

Dilated Eye Examination Record the number of times she/he had a dilated eye examination since the preassessment interview.

Date of last exam Record the date of the participant's last dilated eye exam.

Dentist Record the number of times she/he went to a Dentist since the preassessment interview.

Podiatrist Record the number of times she/he went to a Podiatrist since the preassessment interview.

OB/GYN Record the number of times a female participant went to an Obstetrician/Gynecologist since the preassessment interview.

Mental Health Professional — Record the number of times she/he went to a Mental Health Professional since the preassessment interview.

Urologist — Record the number of times she/he went to Ulrologist since preassessment interview.

Doctor Visit — Record the number of times she/he went to a Doctor for a checkup or illness since the preassessment interview.

Emergency Room Visit — Record the number she/he went to a hospital Emergency Room since the preassessment interview.

Hospital Admissions – Since the Preassessment Interview

Any Cause — Record the total number of times that she/he was admitted overnight to a hospital for **Any Cause** (including diabetes-related).

DM-Related — Ask this question <u>only</u> if the participant reported she/he was hospitalized for Any Cause (above). Record the number of times she/he was admitted to the hospital overnight for a diabetes (**DM – Related**) cause.

DKA/HHNS — Ask this question <u>only</u> if the participant reported she/he was hospitalized for a DM-Related cause (above). Record the number of times she/he was admitted to the hospital overnight because of diabetic ketoacidosis (**DKA**) or hyperglycemic hyperosmolar non-ketotic syndrome (**HHNS**).

Example: Participant reports that he was hospitalized two times since the preassessment interview: one time for any cause (Appendicitis) and one time for DKA. This information would be recorded as follows:

Hospital Admissions:
_2_Any Cause
_1_DM-Related
1 DKA/HHNS

Health Status Assessment: Medical Conditions and Treatment
Check only if applicable. List medication(s)/description as appropriate

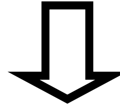
__ Allergies ___________________________
__ Herbal Supplements _________________
__ Tobacco Use ________________________
__ Alcohol Use _________________________
__ Other substance/product use ____________
__ Surgery (Any) ________________________
__ Eye Disease _________________________
__ Heart Disease ________________________
__ Hypertension _________________________
__ Hyperlipidemia _______________________
__ Peripheral Vascular Disease _____________
__ Respiratory Disease ___________________
__ Gastrointestinal Disease _________________
__ Pancreatitis/Pancreatic Surgery __________
__ Renal Disease ________________________
__ Genitourinary Disease __________________
__ Sexual Dysfunction ______________________________
__ Foot Complications ______________________________
__Current Deformity/Ulcer ______________________
__ Amputation, Lower Extremity (Specify) _________
__ Monofilament Test Done _________________________
__ Loss of Protective Sensation ______________________
__ Neuropathy ____
__ Other Neurological Disease _______________________
__ Arthritis/Musculoskeletal Disease __________________
__ Other Endocrine Disease _________________________
__ Cancer ____
__ Mental Health/Psychosocial ______________________
__ Recurring Infection ______________________________
__ Hx DKA/HHNS ___________________________________
__ Recurring Hypoglycemia _________________________
__ Planning/Current Pregnant _______________________
__ Other ____

Health Status Assessment: Medical Conditions and Treatment

Indicate with a check (√) to the left, any conditions noted at the time of One Year Follow-up. Record on the line to the right, medications to treat the condition or other details concerning the condition. A written medical diagnosis is not required. If a condition does not exist, leave the line blank.

________________________________/___________ Signature of Instructor   Date

Signature
After completing the DSMT Program One Year Follow-up Data Form (DSMT/8), the instructor completing the form signs and dates the form.



Note: Documentation of the DSMT Program One Year Follow-up is continued on DSMT/9.

Maine Diabetes Prevention and Control Program
Diabetes Self-Management Training (DSMT/9)
One-Year Follow-up - Page 2

Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone	Address

Name Record participant's name.

Physician Enter the name of the physician who referred the participant to your DSMT Program. Indicate, with a check (√) to the left, the specialty of the physician: **FP/GP** (family practice/general practice); **Ped** (pediatrician); **Int** (internist); **Endo** (endocrinologist); or **Other.**

Address Record participant's mailing address. Blacken out the information on the DPCP copy.

Phone # Record the participant's home phone number.

Content Area **Knowledge Rating** 1 = No 3 = Basic 5 = Comprehensive 2 = Little 4 = Advanced	**Rating**	**Behavioral Assessment/ Current Practice**
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		

Content Area

The Content Area table lists ten areas of diabetes care for which you will evaluate the participant's knowledge, attitudes, behavioral assessment and current practice at the time of the One-Year Follow-up.

Rating (1 - 5) On a scale of 1- 5, assess **knowledge** level of the participant at the time of referral in each content area as follows:

1 = No knowledge
2 = Little knowledge
3 = Basic knowledge
4 = Advanced knowledge
5 = Comprehensive knowledge

Behavioral Assessment/ Current Practice Document Behavioral Assessment and/or Current Practice unique to the participant for each content area. *The knowledge rating will not necessarily reflect current behavior practice.*

Example

Content Area	Rating	Behavioral Assessment/ Current Practice
6. Preventing, detecting, and treating acute complications	3	No daily foot checks. Has stopped smoking. Takes medicine for cholesterol and blood pressure every day.

Plan of Care:

Plan of Care Record other pertinent information concerning the participant's care and/or educational plan to share with team members in the comment section.

Goals Met:

Goals Met Record summary of behavioral goals met.

Measurable Clinical Outcomes Met:

Measurable Clinical Outcomes Met Record summary of clinical goals met such as decrease in A1c value.

Plan:

Plan Record plan of care for participant in next year.

Time Spent: _________Minutes

Time Spent Record the number of minutes spent during one-year follow-up session.

Date for Follow-up DSMT (if appropriate) ____________________________

Date for Follow-up MNT (if appropriate) ____________________________

Date for Follow-up DSMT Record date of next follow-up for DSMT, if appropriate.

Date for Follow-up MNT Record date for next Medical Nutrition Therapy session, if appropriate.

	____________________/_____ Signature of Participant / Date	____________________/_____ Signature of Instructor / Date

Signatures After completing the DSMT Program One Year Follow-up Data Forms (DSMT/8 and DSMT/9), the participant and instructor completing the form sign and date the form.

Form Distribution
Once the DSMT Program One Year Follow-up Data Forms (DSMT/8 and DSMT/9) are completed, one photocopy of each should be made. Please distribute the forms as follows:

Original DSMT/8 and 9	File in participant's permanent record file.
Photocopy of DSMT/8 and 9	It is recommended one photocopy be given to the participant.