

**CARE COORDINATION FORM
DIABETES EDUCATION**



Date: _____ New Participant Established High Risk Participant

Participant Name: _____ Date of Birth: _____ Location: _____

Phone #: _____ E-mail: _____

DSME/S Education-Survival Skills by Phone Start Time: _____ End Time: _____

ASSESSMENT:

- | | | |
|---|---|--|
| <input type="checkbox"/> Newly Diagnosed | <input type="checkbox"/> Needs review of knowledge & skills | <input type="checkbox"/> Long standing diabetes with no prior diabetes education |
| <input type="checkbox"/> Change in medication, activity, and nutrition intake | <input type="checkbox"/> Change in health condition, renal failure, or complicated medication regimen | <input type="checkbox"/> Change in healthcare provider |
| <input type="checkbox"/> Recent Hospitalized | | <input type="checkbox"/> A1C out of target |
| <input type="checkbox"/> Other _____ | | |

Date: A1c % _____ Blood Pressure _____ Weight _____ Height _____

Medications: _____

DIABETES EDUCATION PROVIDED: AADE 7 Self Care Behaviors (English/Spanish)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Healthy Eating | <input type="checkbox"/> Reducing Risk | <input type="checkbox"/> Being Active |
| <input type="checkbox"/> Healthy Coping | <input type="checkbox"/> Taking Medication | <input type="checkbox"/> Monitoring |
| <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Education Handouts | <input type="checkbox"/> Other: _____ |

Set Behavior Goal(s): (1-2 Goals)

- | | |
|--|--|
| <input type="checkbox"/> Limit candy, sugary drinks & desserts | <input type="checkbox"/> Limit High Fat Foods, ex. Beef, ribs, bacon, etc. |
| <input type="checkbox"/> ↑Vegetables servings/day, # _____ | <input type="checkbox"/> Follow plate method |
| <input type="checkbox"/> ↑Physical activity ___X/week ___min/day | <input type="checkbox"/> Take Medications |
| <input type="checkbox"/> Check blood sugar _____ times/day | <input type="checkbox"/> See Healthcare Provider Regularly |
| <input type="checkbox"/> Other: _____ | |

Comments/Notes:



COVID EDUCATION: (CDC Handout Information)

- Social Distancing
- Wash Hands
- Wear Mask
- Cover face when Sneezing/Coughing
- Clean and disinfect

PLAN:

Phone Call Follow-up by Health Education (DSME/S Education continued) Date/Time: _____

Diabetes Education Class Enrollment: Virtual Face-to-Face

Healthcare Provider Visit: Medication Adjustments Medication Refills

Other: _____

EDUCATOR'S SIGNATURE: _____ **Date:** _____

COMMUNITY HEALTH WORKER COORDINATION: Start Time: _____ End Time: _____

COMMUNITY RESOURCES REFERRALS:

- Medication Assistance Food Stamps Food Bank/Pantry Government Housing
- Temporary Shelter Utility Bills (Gas, Light, Water) Indigent Healthcare Clinic
- Transportation Assistance Other _____

Community Health Worker Signature: _____ **Date:** _____