Patient Education & Wellness Program
of Community Care Physicians, P.C.

COMMUNITY CARE PHYSICIANS, P.C.

501 New Karner Road, Suite 1A
Albany, NY 12205
Phone: (518) 713-5347
Fax: (518) 713-5359

Hello and Welcome to the **Patient Education and Wellness Program**. Living with diabetes requires dedicated and ongoing self-care and we are here to help you! Our comprehensive program consists of **3** Diabetes Education sessions *(the 1st and 3rd are individual, the 2nd most likely an informal small group setting)* that will empower you to eat healthfully, take medications safely, develop a plan for physical activity you ENJOY and learn healthy coping and stress management skills. All this supports you in reducing health risks associated with diabetes.

You have been scheduled for an appointment with one of our **Certified Diabetes Care and Education Specialists** (CDCES):

- ☐ Catherine Dascher, RDN, CDN, CDCES
- ☐ Laurie Burton-Grego RD, CDN, CDCES
- ☐ Lisbeth Irish, RDN, CDN, CDCES

On _____ at _____ am/pm for an appointment at the following location: _____

Feel free to bring a family member or friend with you who will support you in your endeavor to make healthy changes.

Insurance verification: Prior to your visit we recommend you contact your insurance company to verify coverage for diabetes education and co-payments for this service. You can call the toll-free number on the back of your insurance benefit card for this information.

Please note the enclosed *no-show and cancellation policy*.

If it is determined that diabetes education is not a covered benefit with your health plan you will be responsible for the education fees.

In order to serve you better please bring the following:

- ✓ the attached information form – filled out by you in advance
- ✓ your health insurance card(s)
- ✓ your glucose meter **and** blood sugar log (if you test blood sugar)
- ✓ insulin pump/pump supplies
- ✓ food log or meal tracking sheets

We look forward to meeting you!
Sincerely,

The Patient Education and Wellness Team

INITIAL VISIT NO SHOW / CANCELLATION POLICY:

INITIAL VISITS CAN LAST UP TO 1 HOUR. DUE TO THE LARGE AMOUNT OF TIME AND LIMITED NUMBER OF THESE VISITS, THERE WILL BE A $100.00 CHARGE FOR PATIENTS THAT DO NOT CALL TO CANCEL OR RESCHEDULE THEIR APPOINTMENTS WITHIN A MINIMUM OF 48 HOURS PRIOR TO THEIR VISITS.

THIS ALLOWS US TIME TO CALL OTHER PATIENTS THAT ARE ON OUR WAITING LIST FOR OUR PROGRAM TO COME IN FOR THEIR INITIAL VISIT.

CONSIDERATION WILL BE GIVEN TO SAME DAY CANCELLATIONS BASED ON WEATHER CONDITIONS.

THANK YOU,

MANAGEMENT

MRN: _____

NEW PATIENT SELF-ASSESSMENT

NAME: _____ DOB: _____ APPT DATE: _____

Health Insurance: _____ E-MAIL: _____

Race: It is known that some medical conditions are more common in certain ethnic groups. Therefore, we ask that you provide us with this information. Thank you.

- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ White
- ☐ Other: _____

Marital Status: Single Married Widowed Divorced

Gender: Male Female Other: _____

Primary spoken language: _____ Primary reading language: _____

How many years of school have you completed? HS: _____ College: _____

Occupation: _____

Do you use a computer? YES NO

MEDICAL and DIABETES HISTORY

Primary Care Provider: _____ Endocrinologist (if any): _____

What type of diabetes do you have?

- ☐ Type1
- ☐ Type2
- ☐ Pre-Diabetes
- ☐ Gestational
- ☐ Latent autoimmune diabetes in adults (LADA)

What year were you diagnosed? _____ Have you had diabetes education before? YES NO

When? _____ Where? _____

Please list any other medical problems you have

_____

_____

Do you have allergies to food or medicine? YES NO

Please list: _____

Do other family members have diabetes? YES NO

Please list who and what type: _____

How tall are you? _____ How much do you weigh? _____

What is your highest adult weight? _____ Lowest? _____

What is your ideal or desired weight? _____

MRN #: _____

MONITORING YOUR DIABETES

What is your most recent A1C? _____ I don't know what that is _____

What brand of meter do you use to test your blood sugar? _____

How many times do you test your blood sugar each day or week? _____

What time(s) of day do you test? _____

Do you keep a record of your blood sugar results? YES NO

What do you consider to be "good" blood sugar readings? _____

What range have your readings been in for the past two weeks? _____

MEDICATIONS

Please list the medications you take for your diabetes and what time of day you take them:

Diabetes Pills: _____

Insulin: _____

Other diabetes injections besides insulin: _____

Vitamins, minerals and herbal supplements: _____

Other medications: _____

USE of INSULIN PUMP and Continuous Glucose Monitoring (CGM). Please answer if applicable

Do you use an insulin pump? YES NO What brand? _____

For how long? _____ Are you here for pump start training or follow up? YES NO

Do you use a *Continuous Glucose Monitor* (CGM)? YES NO What brand? _____

Are you here for a CGM start? YES NO

NUTRITION AND EATING HABITS

Do you follow a special diet or cultural way of eating? YES NO

If yes, please describe _____

How many times a day do you eat? _____ Who does the cooking in your home? _____

Who does the food shopping? _____

Please list 6 items that are always in your shopping cart at the grocery store:

_____

_____

_____

_____

MRN #: _____

What do you typically eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

On an average day, how much of the following beverages do you drink?

Water: _____ Soda_____ Diet or Regular: _____

Juice: _____ Sports drinks: _____ Coffee: _____

Other: _____

How often do you drink alcoholic beverages? _____How much? _____

PHYSICAL ACTIVTY HABITS

What do you do for physical exercise? _____

How many times a week and for how long? _____

What kinds of physical activities do you enjoy doing the most? _____

What prevents you from doing physical activity or exercise? _____

DIABETES PROBLEM SOLVING

Do you check your blood sugar before and during intense physical activity or driving? YES NO

What do you do when your low blood sugar is low? _____

What do you do when you blood sugar is high? _____

Do you carry glucose or extra food with you in case of emergency? YES NO

Do you have and know how to use a glucagon kit? YES NO

Do you wear or carry diabetes identification? YES NO

DIABETES RISK REDUCTION

Do you see a dentist? YES NO If yes, how often? _____

Do you wear dentures? YES NO

Do you have foot problems related to diabetes? YES NO

Do you see a podiatrist? YES NO If yes, how often? _____

Do you see an eye doctor (ophthalmologist or optometrist)? YES NO

When was your last dilated eye exam? _____

Are you a smoker? YES NO If yes, how much do you smoke? _____

Are you a former smoker? YES NO When did you quit? _____

MRN #: _____

Have you ever tried to quit? YES NO Are you interested in getting help to quit now? YES NO MAYBE

HEALTHY COPING WITH DIABETES

Do you go to a support group in your community? YES NO

Would you like to meet other adults living with diabetes for peer support and lifestyle education?
YES NO MAYBE

LEARNING ABOUT YOU

What is the best way for you to learn? _____

Does anything prevent you from learning? _____

What thoughts come to mind when thinking about having diabetes?

_____

What is your greatest concern about living with diabetes? _____

What motivated you to come for diabetes education? _____

Please check the **3 most important things** you want to learn about your diabetes:

- ☐ What to eat
- ☐ Exercise
- ☐ Taking medications
- ☐ Lowering my A1C
- ☐ When to test my blood sugar
- ☐ What my numbers mean
- ☐ Healthy coping
- ☐ Reducing risks for other health problems
- ☐ Diabetes problem solving
- ☐ What other questions do have about living with diabetes?

Other:

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

_____ _____

(Patient signature) (Educator signature)

Date: _____ Date: _____