THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

DIABETES EDUCATION
At CAREPOINT EAST
MARTHA MOREHOUSE
INTERNAL MED HILLIARD
RARDIN FAMILY PRACTICE
COMPREHENSIVE TRANSPLANT

Class Date:_____ **MRN#:**_____

Name:_____ **Address:**_____

Date of Birth:_____ **Phone:(___)**_____ **Cell:**_____

Occupation:_____ **Diabetes Doctor:**_____

Have you been to diabetes education before? Yes No **If yes, When?** _____

If someone is coming to class with you, what is your relationship?_____

Medical History	_____Independent	_____Needs Review	_____Needs Referral	_____Not Assessed

Type of Diabetes: Type 1 Type 2 Pre-Diabetes Other **Diagnosis year:**_____

Circle medical history:

Heart Disease	Kidney Disease	Slow Digestion
High Blood Pressure	Anxiety	Eye Problems
High Cholesterol	Depression	Skin Problems
High Triglycerides	Nerve Damage	Foot Problems

Do you use tobacco? Yes / No **Circle all that apply.**

Cigarette E-Cigarette Chewing Cigar Pipe Date Quit: _____

Circle if completed in the past 12-months:

A1C *(Result_____)* Eye Exam Foot Check Flu Shot Cholesterol Teeth Cleaning

Blood Sugars	_____Independent	_____Needs Review	_____Needs Referral	_____Not Assessed

How often do you check blood sugar? _____ **Do you keep a log?** Yes No

What is your blood sugar at: Breakfast_____ Lunch _____ Dinner _____ Bed _____

What are your signs of *HIGH* blood sugar & how do you treat?_____

Do you test your Ketones? Yes No Not Sure

What are your signs of *LOW* blood sugar & how do you treat? _____

Do you have glucagon? Yes No Not Sure **Is someone trained to use it?** Yes No

Has EMS been called or have you gone to the hospital for high or low blood sugar?

Describe: _____

NAME: **MRN:**

Pump Details	_____Independent	_____Needs Review	_____Needs Referral	_____Not Assessed

What type of insulin pump do you have? _____

How old is your current pump? _____**What year did you start pump therapy?**_____

Carb Ratio	Target Blood Sugar	Correction / Sensitivity	Basal Rates
12:00am _____	**12:00am** _____	**12:00am** _____	**12:00am** _____
_____ _____	_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____	_____ _____

Where is your insulin stored: **Unopened?**_____ **Opened?**_____

How often do you miss a dose of insulin? _____

Do you use Extended, Square, Dual or Combo Bolus? Yes No **Temporary Basal?** Yes No

How often do you change your infusion set?_____

List problems with your infusion sets:_____

List problems getting your diabetes supplies/medicine: _____

Nutrition	_____Independent	_____Needs Review	_____Needs Referral	_____Not Assessed

How many days a week do you eat: Breakfast_____ Lunch _____ Dinner_____

How many regular sugar drinks do you consume weekly?_____ **Alcoholic drinks?**_____

Do you know how to carb count? Yes No

Feet/Exercise	_____Independent	_____Needs Review	_____Needs Referral	_____Not Assessed

How often do you check your feet? Never Daily Monthly **List problems:** _____

What type of exercise do you do?_____

No. days/week?_____ **Length?**_____

	_____Independent	_____Needs Review	_____Needs Referral	_____Not Assessed

What are your feelings about diabetes?_____

Do you have any difficulty with: Seeing Hearing Reading Speaking Dexterity

What do you want to learn in session?_____

How willing are you to make changes to your lifestyle? (1= not willing, 5 = very willing) 1 2 3 4 5

NAME: MRN:

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Please **rate your knowledge** on each topic using a scale of 0 to 3.

0 = No knowledge
1 = Some knowledge
2 = I understand
3 = I am an expert

Before Class 1, fill out columns “Before Class" and "I want more information about this topic.” At the end of class 2, fill out the column "After Class 2"

TOPIC	**Before Class 1**	**I want more information about this topic (check mark)**	***After Class 2***
I know the difference between Type 1 & Type 2 Diabetes			
I know how, when and why to check my blood sugar			
I know my target blood sugar and A1c level			
I recognize and can treat low and high blood sugars			
I can manage my diabetes when I am sick			
I am able to count carbohydrates and know which fats are heart healthy			
I recognize three reasons physical activity benefits me			
I can state my medicine and know why I am taking it			
I am aware of long-term and short-term complications			
I can identify how stress affects my diabetes			

Turn Over

OSU Internal Medicine, LLC Group Visit Consent Form

Group visits are shared medical appointments in which multiple patients participate, sharing information about themselves and their medical status. Each patient's participation is strictly voluntary. The effectiveness of the group appointment is dependent upon a sharing of information by and among the participants. It is impossible to prevent protected medical information from being shared amongst the participants.

To be eligible to participate in a group medical visit, you must agree to respect the privacy of the other participants, and agree to keep their information confidential. Patients need to feel comfortable that they can participate in the group without their personal and medical information being shared outside of the group or used without their knowledge. You agree you will not make written notes, document or otherwise record any medical or personal information about group participants, without their written approval, and that you will not disclose any other participant's medical or personal information to any one outside of the group medical visit.

OSU Internal Medicine, LLC (OSU IM), as the sponsor of the group medical visit, requires participants to sign a confidentiality agreement stating they will not repeat or share protected medical information or other personal information outside of the group; however, we cannot guarantee that all participants in the group will comply with the terms of the confidentiality agreement. Participant agrees to accept this risk.

Confidentiality Agreement and Consent

By signing this confidentiality agreement, I agree to keep all medical and personal information of group participants confidential. I agree that I may be excluded from the group if I fail to keep information confidential.

I agree to allow OSU IM to share my name and medical information during the group visit, including information on my health, nutritional and medical conditions.

I release OSU IM from any and all liability, claims, damages and/or expenses resulting from any other participant's violation of their confidentiality agreement.

This release shall be effective as long as I am participating in a group.

Name (*please print):*_____

Signature:_____ **Date**: _____