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

<table>
<thead>
<tr>
<th>Name (Last)</th>
<th>First</th>
<th>M.I.</th>
<th>Physician’s Name: FP/GP_ Ped_ Int_ Endo_ Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

---

**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

### 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 (Inches)
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 (lbs)
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.
### 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

### 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. 4hr or Overnight).
<table>
<thead>
<tr>
<th><strong>Race</strong></th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnic</strong></td>
<td>Hispanic or Latino, Non-Hispanic or Latino</td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td>Lipid Profile Date</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>M__ F__</td>
</tr>
<tr>
<td><strong>Height (Inches)</strong></td>
<td>Total Cholesterol</td>
</tr>
<tr>
<td><strong>Weight (lbs)</strong></td>
<td>HDL-C__________ LDL-C__________</td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td><strong>/</strong>________</td>
</tr>
<tr>
<td><strong>Year of Onset</strong></td>
<td>Annual Microalbumin Screen</td>
</tr>
<tr>
<td><strong>HbA1c</strong></td>
<td>__ Proteinuria Present</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>__ Proteinuria Absent/Screen done</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>Screen Result</td>
</tr>
<tr>
<td><strong>Screen Test Used:</strong></td>
<td>__ Albumin-to-Creatinine Ratio (Spot)</td>
</tr>
<tr>
<td></td>
<td>__24 hour Collection</td>
</tr>
<tr>
<td></td>
<td>__Timed Collection(e.g. 4hr of Overnight)</td>
</tr>
</tbody>
</table>

**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

**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

**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/HNNS

**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:

<table>
<thead>
<tr>
<th>Hospital Admissions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Any Cause 1 DM-Related 1 DKA/HHNS</td>
</tr>
</tbody>
</table>


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

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.
Name (Last)  (First)  (M.I.)  

Name (Last)  (First)  (M.I.)  

Physician’s Name:  

Physician’s Name:  

Phone  Address  

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 (v) 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.  

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Rating</th>
<th>Behavioral Assessment/ Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes disease process/treatment options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing, detecting, and treating acute complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing (risk reduction), detecting, and treating chronic complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal-setting and problem solving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preconception care, pregnancy, and gestational diabetes management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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  4 = Advanced knowledge  
2 = Little knowledge  5 = Comprehensive knowledge  
3 = Basic 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

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Knowledge</th>
<th>Behavioral Assessment/Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Preventing, detecting, and treating acute complications</td>
<td>3</td>
<td>No daily foot checks. Has stopped smoking. Takes medicine for cholesterol and blood pressure every day.</td>
</tr>
</tbody>
</table>

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:

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Distribution Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original</strong> DSMT/1 and DSMT/2:</td>
<td>File in participant’s permanent record file (if applicable)</td>
</tr>
<tr>
<td><strong>Photocopy</strong> of DSMT/1 and DSMT/2:</td>
<td>It is recommended one photocopy be given to participant.</td>
</tr>
</tbody>
</table>
# Maine Diabetes Prevention and Control Program  
**Diabetes Self-Management Training (DSMT/3)**  
**Postassessment**

<table>
<thead>
<tr>
<th>Name (Last)</th>
<th>(First)</th>
<th>(M.I.)</th>
<th>Physician’s Name:</th>
<th>Phone</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><em><strong>FP/GP</strong> Ped</em>_ Int__ Endo__ Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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>
<thead>
<tr>
<th>Curriculum Taught</th>
<th>Knowledge Rating</th>
<th>Behavioral Assessment/ Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1:1 □ Group</td>
<td>1—No</td>
<td></td>
</tr>
<tr>
<td>□ Special condition exists that contraindicates participation in a group session i.e. Language, Hearing, Cognitive, Visual Barriers Assessment</td>
<td>2—Little</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3—Basic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4—Advanced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5—Comprehensive</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minutes</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Diabetes disease process/treatment options
   1. 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

---

**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 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:**

<table>
<thead>
<tr>
<th>Curriculum Taught</th>
<th>Date</th>
<th>Initials</th>
<th>Time Minutes</th>
<th>Rating</th>
<th>Behavioral Assessment/Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1 Group</td>
<td>1/6/01</td>
<td>J.D.</td>
<td>15</td>
<td>3</td>
<td>Checks blood glucose 4x/day, fasting and pp.</td>
</tr>
</tbody>
</table>
Plan of Care

Record other pertinent information concerning the participant’s care and/or educational plan for the coming year.

<table>
<thead>
<tr>
<th>Date of Next Follow-up</th>
<th>Signature of Participant/Date</th>
<th>Signature of Instructor/Date</th>
</tr>
</thead>
</table>

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.
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

<table>
<thead>
<tr>
<th>New</th>
<th>Rev</th>
<th>Cont</th>
<th>Date</th>
<th>Initials</th>
<th>Behavior Goal</th>
<th>Goal Category</th>
<th>Success Noted</th>
<th>Date</th>
<th>1-3</th>
<th>4-5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**New**

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.
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 Goals/Plan of Care

<table>
<thead>
<tr>
<th>New Rev Cont</th>
<th>Date</th>
<th>Initials</th>
<th>Behavior Goal</th>
<th>Goal Category</th>
<th>Date</th>
<th>1-3</th>
<th>4-5</th>
</tr>
</thead>
</table>

#### Goal Category

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

**Note:** 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

---

**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
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)

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
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, or 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:

Moved, Deceased

Clinical Data Since Last Encounter (If Applicable)

<table>
<thead>
<tr>
<th>Weight (lbs)</th>
<th>Annual Microalbumin Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Proteinuria Present</td>
</tr>
<tr>
<td>HbA1c</td>
<td>Proteinuria Absent/Screen done</td>
</tr>
<tr>
<td>Range</td>
<td>Screen Result</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>Lipid Profile Date</td>
<td>Screen Test Used:</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td><em>Albumin-to-Creatinine Ratio (Spot)</em></td>
</tr>
<tr>
<td>HDL-C</td>
<td><em>24-hour Collection</em></td>
</tr>
<tr>
<td>LDL-C</td>
<td><em>Timed Collection (e.g. 4 hr or Overnight)</em></td>
</tr>
<tr>
<td>Triglycerides</td>
<td></td>
</tr>
</tbody>
</table>

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

**Note:** 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:

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

**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

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Rating</th>
<th>Behavioral Assessment/Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diabetes disease process/treatment options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Preventing, detecting, and treating acute complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Preventing (risk reduction), detecting, and treating chronic complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Goal-setting and problem solving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Psychosocial adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Preconception care, pregnancy, and gestational diabetes management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Nutritional management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(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:

<table>
<thead>
<tr>
<th>Original DSMT/5, 6 or 7</th>
<th>File in participant's permanent record file.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photocopy of DSMT/5, 6 or 7</td>
<td>It is recommended one photocopy be given to participant.</td>
</tr>
<tr>
<td>Name (Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**or**  

**Dropped-out**  
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
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).
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

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

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 Urologist 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 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.

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).

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
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.
### 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.

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Rating</th>
<th>Behavioral Assessment/Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes disease process/treatment options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing, detecting, and treating acute complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing (risk reduction), detecting, and treating chronic complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal-setting and problem solving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preconception care, pregnancy, and gestational diabetes management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Rating</th>
<th>Behavioral Assessment/ Current Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Preventing, detecting, and treating acute complications</td>
<td>3</td>
<td><strong>No daily foot checks. Has stopped smoking. Takes medicine for cholesterol and blood pressure every day.</strong></td>
</tr>
</tbody>
</table>

### 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:**

Record summary of behavioral goals met.

**Measurable Clinical Outcomes Met:**

Record summary of clinical goals met such as decrease in A1c value.

**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.
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.