Diabetes Treatment Center

DESERT SPRINGS HOSPITAL
MEDICAL CENTER
A Member of The Valley Health System

Patient Information

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Birth Place _____Primary Language Spoken _____

Religion: _____ Race: _____ Marital Status: _____

Patients S.S.#: _____ Patient's Employer: _____

Employer's Address: _____ Work #: _____

Occupation: _____Email Address: _____

1st Insurance Name: _____ Member's Name: _____

Member's DOB: _____ Member's S.S.#: _____ Rlt to Pt.: _____

Member's Employer: _____ Member's Occupation: _____

Employer's Address: _____Work #: _____

2nd Insurance Name: _____ Member's Name: _____

Member's DOB: _____ Member's S.S.#: _____ Rlt to Pt.: _____

Member's Employer: _____Member's Occupation: _____

Employer's Address:_____Work #:_____

Have You Ever Received Services at DSH Before? _____

Have You Ever Received Diabetes Education Before: _____ When: _____ Where: _____

Primary Care Physician: _____Phone #: _____

Referring Physician: _____Phone #: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____ or Cell #_____

Educational Learning Needs Assessment

Have you participated in any diabetes education in the past? No_____ Yes_____
If so, When/Where_____

Language:
Language Spoken/Preferred English_____ Spanish_____Other_____
Specify_____ Interpreter Services Needed? Yes_____ No_____
Reading Preference: English_____ Spanish_____ Unable to Read_____
Other,Specify_____Describe_____

Religious/ Cultural Practices: Do you have any religious or cultural practices that may alter/impact your care/education? No____ Yes___ If so, describe_____

Physical Limitations: Do you have any physical limitations that may alter/impact your learning ability? Yes____ No_____ If so, Describe_____

Learning Preference: Do you have a preference for method(s) of learning? Yes_____No_____
If so, Specify_____
Barriers to Learning (Vision/Auditory/Literacy/Language): _____

How important is it to you to follow a diabetes self -management plan that works for you, where 0 is not important at all and 10 is very important? (circle one)

0 1 2 3 4 5 6 7 8 9 10

How confident are you that you can follow a diabetes self- management plan that works for you, where 0 is not sure at all and 10 is very sure? (circle one)

0 1 2 3 4 5 6 7 8 9 10

Information provided by: _____ Educator's Signature: _____

----------**OFFICE USE ONLY**----------

Onset:_____Type: _____Meter: Yes No Name of Meter:_____

Medication/Diabetes: _____

Services: ( ) Individual ( ) Group ( ) 4hr Basic Mgt/Core ( ) Comp. Program ( ) Nurse

( ) Meter Teach ( ) Follow-Up ( ) Dietitian ( ) Gestational ( ) CGMS ( ) Insulin Instruction

Age: _____Sex: ____ Height: _____ Weight: _____

Gestational Prior Weight: _____Weeks: _____ Lost/Gained/Stable ( ) Single birth ( ) Twins

Usual meal times: Breakfast_____ Lunch_____Dinner:_____Bedtime_____

SpecialComments: _____

Appointment Date/s: _____ Time/s: _____

( ) Monday ( ) Tuesday ( ) Wednesday ( ) Thursday ( ) Friday ( ) Saturday