

Name: _____

Date: _____

Follow-up Plan – Adults

Recommendations: Dentist Foot Doctor Eye Doctor Quitting smoking
 Dietitian Flu vaccination Pneumonia vaccination Diabetes ID
 Public health/Visiting Nurse Support group _____
 Social Worker Other _____
 A1c Cholesterol HDL LDL Triglycerides Microalbuminuria
Other _____

Behavior Change goal:

Specific behavior to be changed _____
How you will change the behavior _____
How will the behavior change improve your health or quality of life? _____

Signature _____



Follow -up Assessment

Date: _____

How successful are you with your behavior change goal: Never Sometimes Usually Always

If not successful, why not? _____

Did you follow-through with recommendations (see above) Yes No Why not? _____

How is your current health Poor Fair Good Excellent

How frequently do you check your blood sugar? _____ and what does it range? _____ Do you like the blood sugars you're seeing? _____

How often do you follow your meal plan? Not applicable Rarely or never

Occasionally Often Always

How often do you do a self-foot exam? _____

How often are you physically active? _____

Are you able to do the following?

Oral medication/Insulin use: Not applicable Poor Fair Good Excellent

Blood sugar meter use: Poor Fair Good Excellent

Foot Exam Poor Fair Good Excellent

How sure are you that you can manage diabetes: Not sure Somewhat sure Very sure

Date/s of any hospital stays for diabetes since class: _____

My diabetes is a: Disaster Burden Problem Challenge Opportunity Other

Write one example of how you used what you learned about diabetes during the _____ class/es _____

What has changed in your diabetes care since the class/es? _____

For Instructional Staff Only

Additional interventions provided/follow-up needed

See Ed. Record _____

Signature _____