Participant Name: _____ **DOB:** _____ **Referring Provider:** _____

American Diabetes Association. Education Recognition Program

Assessment/Scale: **1= needs instruction** **2= needs review** **3= comprehends key points** **4= demonstrates understanding/competency** **NC= not covered** **N/A= not applicable**

Diabetes Self-Management Education and Support Participant Record

Topics Learning Objectives	Initial	Initial or Post Srvc	Initial or Post Srvc	Initial or Post Srvc	Initial or Post Srvc	Initial or Post Srvc	Initial or Post Srvc	Post Service	Comments
	Pre Edu-Assessment/ Education Plan	Edu outcome or reassess	Edu outcome or reassess	Edu outcome or reassess	Edu outcome or reassess	Edu outcome or reassess	Edu outcome or reassess	Edu outcome or Reassessment	
Educator Initial:									
Date:									
Diabetes Pathophysiology *Define diabetes and identify own type of diabetes; list 3 options for treating diabetes*									
Healthy Eating *Describe effect of type, amount and timing of food on blood glucose; list 3 methods for planning meals*									
Being Active *State effect of exercise on blood glucose levels*									
Taking Medications *State effect of diabetes medicines on diabetes; name diabetes medication taking, action and side effects*									
Monitoring Glucose *Identify recommended blood glucose targets and personal targets*									
Acute Complications *List symptoms and treatment of hyper- and hypoglycemia, DKA, sick day guidelines and guidelines for severe weather or situation crisis and diabetes supply management*									
Chronic Complications *Define the relationship of blood glucose levels to long term complications of diabetes and screening and preventative measures*									
Lifestyle and Healthy Coping *Describe lifestyle and healthy coping strategies to promote diabetes self-management*									
Diabetes Distress and Support *Recognize diabetes distress and be able to identify support options*									

Participant Selected Behavioral Goal/s and Outcomes: _____

_____

Clinical or Quality of Life Outcomes/s: _____

Comments: _____

Clinician Signature: _____ **Clinician Signature:** _____

Instructions for Form Use:

This form can be used for initial comprehensive DSMES and for post program DSMES. The top two rows of the above table are used to indicate this.

Top Row: Indicate if the participant visit/session is initial comprehensive DSMES or post program DSMES.

Second Row: Indicate if the column is being used to document education outcomes or re-assess the participant's needs.