TMH PHYSICIAN PARTNERS

The Diabetes Education Programs of the
TMH Physician Partners – Metabolic Health Center
2633 Centennial Blvd, Suite 100
Tallahassee, Fl. 32308
(850) 431- 5404/Fax 431-4838

Dear Patient and Family:

We would like to welcome you to The Diabetes Education Programs of the Metabolic Health Center! Our program was established to help people learn how to control their diabetes. Our staff of certified diabetes educators will help you learn about diabetes and the tools you need to manage it successfully.

Once we receive a completed referral from your doctor, we will call to schedule your appointment. Please bring the appropriate paperwork (registration packet and patient history forms) and provide it to our front office staff at the time of your first appointment. Also, bring your insurance card(s), photo identification, and blood glucose machine if you have one. If you are unable to complete the paperwork before your scheduled appointment, please call us to reschedule.

Please note that your insurance company will be billed for these services unless other arrangements were made before your scheduled appointment. You will be responsible for any non-covered benefits, unmet deductible, co-payment, or coinsurance. Should you have any questions regarding insurance coverage, please call your insurance company directly first and let them know that we are a hospital outpatient facility and the procedure code is G0108. After speaking with your insurance company, if you have any additional questions, please do not hesitate to call us.

If you have any questions or need to change your appointment time or date, please contact our office at 850/431-5404, option 3. If you need to cancel your appointment, please let us know 24 hours in advance so that we may accommodate patients waiting for an appointment. (You also may be asked to reschedule your appointment if you arrive 10 minutes late.)

We look forward to meeting you and helping you manage your diabetes.

Sincerely,

TMH PP Metabolic Health Center Administration

TALLAHASSEE MEMORIAL METABOLIC HEALTH CENTER
PEDIATRIC DIABETES SELF–MANAGEMENT QUESTIONNAIRE

Patient Name_____**Sex**_____ **Age**_____ **DOB** _____

Diabetes Diagnosis □ **Type 1** □ **Type 2** □ **Unsure**

Date of diagnosis_____ When did you and your child last receive diabetes education? _____

Please circle which therapy child is using:: Insulin injections Insulin pump (brand_____) Diabetes pills

MONITORING

Brand of meter that child is using _____ How many meters does child have? _____

How many times per day is blood sugar checked? _____ At what times? _____

List any problems with blood glucose monitoring _____

If child has a continuous blood glucose monitor (CGM), list name_____

List the name and relationship of parent(s)/guardian(s) the child lives with and circle if lives with person full-time or part-time:

Name_____ Full-time Part-time

Name_____ Full-time Part-time

Name_____ Full-time Part-time

Please list name, age, and relationship of all other persons living with the child: _____

_____

List name and relationship of anyone else who helps manage child's diabetes _____

Child's school or daycare_____ Grade _____ Phone #_____

Does your child have a diabetes plan for school? □No □Yes Name of clinic nurse or aide_____

Name of After School Program_____

MEDICAL HISTORY

Does your child or any other family member have any of the following health problems:

Anxiety/depression	□No	□Yes	If yes, who?_____
Asthma	□No	□Yes	If yes, who?_____
Celiac disease	□No	□Yes	If yes, who?_____
Constipation/diarrhea	□No	□Yes	If yes, who?_____
Heart disease	□No	□Yes	If yes, who?_____
High blood pressure	□No	□Yes	If yes, who?_____
High cholesterol	□No	□Yes	If yes, who?_____
Kidney disease	□No	□Yes	If yes, who?_____
Diabetes	□No	□Yes	If yes, who and what type? _____

Other medical information to help us better know your child:_____

_____

Please list any surgery (and year) child has had_____

…OVER…

Patient Name _____ DOB_____

SOCIAL HISTORY

How does your child learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Hands-on ☐ Other: _____

Have you ever attended ☐diabetes support event ☐diabetes camp ☐family weekend or ☐other program about diabetes?
☐No ☐Yes When?_____

Are you part of the Diabetes Family Support Group mailing list? ☐No ☐Yes If no, would you like to be? _____
Email address_____
Would you like to join our Diabetes Family Support Facebook Group? ☐No ☐Yes

Are there any personal or family events or concerns that we should be aware of such as divorce, moving, school problems?
_____

Are there any concerns about the safety of the child or family? ☐No ☐Yes _____

Have you noticed your child experiencing the following: ☐ Increased sadness ☐ Increased irritability ☐ Increased isolation
☐ Changes in sleeping patterns ☐ Loss of pleasure ☐ Thoughts of suicide ☐ None of these

Please circle any of the following that your child uses: Alcohol Tobacco Recreational drugs

NUTRITION AND PHYSICAL ACTIVITY:

List sports or afterschool activities does _____

List any physical limitations _____List any concerns about child's growth _____

List any concerns about child's food choices? _____

List child's meal plan (carb counting, etc.) _____

Who does the cooking and grocery shopping in home? _____ Does child drink sugar-sweetened beverages? ☐No ☐Yes

If child has any food intolerances or allergies, please list_____

Any food practices that we should be aware of? (such as vegetarian or no pork) _____

Please specify any religious/cultural or personal health beliefs that you would like us to consider as we help you develop your child's diabetes care plan: _____

	Where is child usually? (School, home, grandma's, etc.)	Typical Foods and Beverages
Breakfast/ Time _____	_____	_____
Lunch/ Time _____	_____	_____
Dinner/ Time _____	_____	_____
Snacks/ Times_____	_____	_____

Please circle one answer in the statements below:

Within the past 12 months we worried whether our food would run out before we got money to buy more.
Often True **Sometimes True** **Never True** for your household

Within the past 12 months the food we bought just didn't last and we didn't have money to get more.
Often True **Sometimes True** **Never True** for your household