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

PEDIATRIC DIABETES SELF–MANAGEMENT QUESTIONNAIRE

Patient Name_____ Sex_____ Age_____ DOB _____ Race_____

Mailing Address_____

Diabetes Physician_____ Primary Care Physician_____

Date of diagnosis_____ When did your child last see a diabetes educator? _____

What language do you prefer using in discussing your child's health care? ❑English ❑Other:_____

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:

_____

PARENT/GUARDIAN INFORMATION

Name_____Relationship_____ Occupation_____

Home phone_____Work phone_____Cell phone_____

Name_____Relationship_____ Occupation_____

Home phone_____Work phone_____Cell phone_____

Please give the name, age, and relationship of all persons living with the child:

_____

_____

Child's school or daycare_____ Grade _____ Phone #_____

Does your child have a school diabetes care plan?❑No ❑Yes
Name of Nurse or Clinic Aide_____

MEDICAL HISTORY

Please list all food/medication allergies for child_______

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?	_____

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

_____

MONITORING

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

How many times each day is blood sugar tested?_____ At what times?_____

Is child having any problems with blood glucose monitoring?_____

…OVER…

Patient name _____ **DOB**_____

SOCIAL HISTORY

Is anyone helping your child with diabetes management? ❑No ❑Yes If yes, who? _____

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

Have you ever attended ❑diabetes support group ❑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_____

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: ❑ Increasing sadness ❑ Increased irritability ❑ Increased isolation
❑ Changes in sleeping patterns ❑ Loss of pleasure ❑ Thoughts of suicide

Does the patient use alcohol, tobacco, or recreational drugs? ❑No ❑Yes_____

NUTRITION AND EXERCISE

Child's extracurricular activities? What_____ When_____

Any physical limitations? _____Are there any concerns about child's growth?_____

Are there any concerns about child's food choices? _____

Is child on any kind of meal plan? (such as carb counting)_____

Who does most of the cooking and grocery shopping in your home? _____ Child's favorite beverages: _____

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

Child's Daily Schedule:

	Where is child usually? (School, home, grandma's, etc)	Typical Foods
Breakfast/ Time _____	_____	_____
	_____	_____
Mid-Morning/ Time _____	_____	_____
Lunch/ Time _____	_____	_____
	_____	_____
Mid-Afternoon/ Time _____	_____	_____
Dinner/ Time _____	_____	_____
	_____	_____
Before bed/ Time_____	_____	_____

Signature of parent/guardian_____Date_____

Reviewed by Clinician_____Date/Time_____

Rev 01/16

For Office Use Only
ICD-10- Code: _____

PATIENT MEDICATION and SUPPLEMENT LIST

Name:_____ DOB:_____ Physician:_____
Pharmacy:_____
Medication Allergies:_____

Medication name	Dose	Taken by	Frequency (times per day)
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
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Reviewer Signature/Date/Time

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

** Notice to Patient** Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.