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
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: ____________________________________________________________

<table>
<thead>
<tr>
<th>Breakfast/Time</th>
<th>Where is child usually? (School, home, grandma’s, etc.)</th>
<th>Typical Foods and Beverages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunch/Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dinner/Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snacks/Time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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