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| --- | --- |
| **Texas Workforce Solutions logo** | **Texas Workforce Commission****Vocational Rehabilitation Services****Diabetes Self-Management Education Assessment**   |
| **Instructions** |
| * Complete all appropriate fields. Boxes not marked indicate it does not apply to this customer.
* Develop education and support plan in the “overall recommendations” section.
* Set behavior change goal for next visit.
* As appropriate, you may use the following abbreviations: NA for “not applicable”, ND for “not disclosed by customer”, or NE for “not evaluated”.
 |
| **Customer Information**  |
| **Customer name:**      | **TWS-VRS Case ID:**      |
| **Referral date:**      | **Counselor name:**      | **Service authorization number:**      |
| **Customer Demographics**  |
| **Age:**      | **Sex:** (check box):     [ ]  M [ ]  F | **Marital status:** [ ]  Married [ ]  Divorced [ ]  Single [ ]  Widowed | **Number in household** (including customer):      |
| **Physician name, specialty, and contact information handling Diabetes Management:**       |
| **Primary and secondary insurance (if applicable):**      |
| **Can customer meet diabetes-related expenses** (e.g. nutritional needs, medications, test strips)**?**[ ]  Yes [ ]  No |
| **If no, enter explanation and/or comments:**      |
| **Community resources used by customer:** |
| **Support System**   |
| **Primary support person and relationship:**      | **Telephone number:**(   )       |
| **Does the customer have disability assistance available when needed?** [ ]  Yes [ ]  No |
| **Does the customer currently receive home health services?** [ ]  Yes [ ]  No |
| **Does the customer belong to and/or attend any diabetes or disability support groups?** [ ]  Yes [ ]  No |
| **Diabetes History**    |
| **Diabetes:** [ ]  Type 1 [ ]  Type 2 [ ]  Gestational Duration:       years |
| **Has the customer participated in formal diabetes education in the past?** [ ]  Yes [ ]  NoIf yes, when?       |
| **Does the customer understand the pathophysiology of diabetes?** [ ]  Yes [ ]  No |
| **Does the customer have any of the following lifestyle or risk factors?**  (Please report any risk factors that may affect the customer’s ability to participate in rehabilitation training to the VRC or OIB Worker directly.)   [ ]  Family history of diabetes [ ]  Over age 45 [ ]  Unhealthy alcohol consumption [ ]  Smoking[ ]  High blood pressure [ ]  Obesity |
| **Customer’s height:**       **Customer’s weight:**       lb. |
| **Does the customer currently have or has been told he or she is at high risk for any of these complications?**   [ ]  Foot problems [ ]  Neuropathy [ ]  Renal problems [ ]  Cardiovascular problems[ ]  Other complications (describe):       |
| **Has the customer been to the emergency room or hospitalized in the last 6 months?** [ ]  Yes [ ]  No If yes, explain:       |
| **Diabetes Self-Management Education Assessment**   |
| **Vocational Rehabilitation (for VR customers only)**    |
| **What is the customer’s previous occupation?**       |
| **What is the customer’s current occupational goal?**       |
| **Has the customer ever missed work or school because of diabetes?** [ ]  Yes [ ]  No |
| **Does the customer need frequent breaks for self-care at work?** [ ]  Yes, for frequent snacks and meals [ ]  Yes, for monitoring [ ]  Yes, for medication [ ]  No |
| **Is the customer able to monitor his blood sugar independently?**  [ ]  Yes, with audio meter [ ]  Yes, with non-audio meter [ ]  No, but wants training to be independent [ ]  No, is unwilling or unable to monitor independently |
| **Does the customer understand diabetes-related impact on employment?**  [ ]  Yes [ ]  No, but customer is ready to learn [ ]  No, and customer is unwilling or unable to learn |
| **Does the customer have a plan for discussing his or her diabetes with people at work?** [ ]  Yes, customer is comfortable sharing information about diabetes and managing it in front of co-workers[ ]  Yes, customer understands the importance of discussing diabetes with co-workers, but wants to settle in before beginning the conversation[ ]  No, customer needs instruction on what to discuss with co-workers and how[ ]  No, customer feels that diabetes is a personal matter and none of the co-worker’s business |
| **Comments and recommendations regarding Vocational Rehabilitation:**      |
| **Healthy Eating (VR and OIB)**    |
| **Does the customer understand the effect of these foods on blood sugar?** [ ]  Carbohydrates [ ]  Proteins [ ]  Fats[ ]  None of these. Customer needs full education on the macronutrients |
| **Can the customer verbalize appropriate portion sizes?**  [ ]  Carbohydrates [ ]  Proteins [ ]  Fats [ ]  No. Customer needs training on portion sizing |
| **Is the customer able to verbalize healthy meal options?** [ ]  Breakfast [ ]  Lunch and Dinner [ ]  Snacks [ ]  No. Customer needs training on meal options. |
| **Does the customer understand the importance of timing of meals?** [ ]  No, needs full education on timing of foods and medications[ ]  Customer’s meals are well spaced but needs information about timing and medication[ ]  Yes, customer follows meal and medication plan at least 80% of the time |
| **What concerns does the customer have regarding healthy eating?** [ ]  Food preferences [ ]  Religious or cultural considerations [ ]  Cost and availability of healthy foods[ ]  No concerns |
| **Does the customer need education on these eating habits?**  [ ]  Restaurants, Alcohol, and fast food [ ]  Ability to prepare healthy foods[ ]  Dietary restrictions related to health status (low fat, low salt, renal, etc.) [ ]  None of these concerns |
| **Comments or recommendations regarding healthy eating:**      |
| **Being Active (VR and OIB)**   |
| **What physical problems limit the customer’s ability to exercise?** [ ]  Hypoglycemia or Hyperglycemia [ ]  Physical disability [ ]  Motivation[ ]  Customer should be able to participate in exercise. |
| **Does the customer have resources for exercise?** [ ]  Treadmill, stationary bike, or other cardiovascular equipment [ ]  Weights [ ]  Workout videos or games [ ]  None |
| **What activities has the customer enjoyed in the past?**      |
| **What activities would the customer like to do?**      |
| **What is the customer’s current exercise level?** [ ]  None [ ]  Seldom. Customer exercises less than one hour per week[ ]  Occasionally. Customer exercises two to four hours per week[ ]  Regular. Customer exercises five or more hours per week |
| **Comments or recommendations regarding being active?**      |
| **Monitoring (VR and OIB)**   |
| **Does the customer have a blood glucose meter and testing supplies?** [ ]  Yes, an audio meter and supplies [ ]  Yes, a meter and supplies without audio features[ ]  No, customer needs an audio meter and supplies[ ]  No, customer wants a meter and supplies without audio features |
| **Current meter:**      | **Frequency of testing:**      |
| **Current blood glucose reading:** [ ]  Premeal [ ]  Post meal Date:       Time:       Result:       | **Does the customer know his or her most recent A1c?**[ ]  Yes [ ]  No Result:       |
| Does the customer:    | [ ]  Understand how to use the meter and get a drop of blood to the test strip | [ ]  Show willingness to monitor his or her blood sugar? | [ ]  Need education or motivation to monitor  | [ ]  Monitoring is not recommended for this customer |
| **Does the customer know how to respond to the results?** [ ]  Yes, regarding adjustments in medications [ ]  Yes, regarding adjustments in food[ ]  Yes, regarding treatment of hypoglycemia and hyperglycemia and seeking medical help[ ]  No, Customer does not know how to respond to the results |
| **Is the customer able to verbalize appropriate results?** [ ]  Customer can verbalize individual blood sugar goals [ ]  Customer can verbalize Hemoglobin A1c goals[ ]  Customer can verbalize blood pressure goals [ ]  Customer needs training on monitoring goals |
| **Does the customer monitor other health metrics?** [ ]  Weight [ ]  Ketones [ ]  Blood pressure [ ]  none of these |
| **How does the customer currently check his or her blood pressure?** [ ]  Doctor’s office [ ]  Pharmacy or grocery [ ]  Home [ ]  Does not check |
| **What keeps the customer from monitoring?** [ ]  Customer does not believe the results are useful [ ]  Customer is unable to perform tasks independently[ ]  Cost and availability of supplies [ ]  Customer currently monitors appropriately. |
| **Is the customer able to:** [ ]  Retrieve values from the meter’s memory and/or keep a record of results of blood sugars and other data[ ]  Dispose of lancets and syringes appropriately[ ]  Adjust his or her diet, medication, and activity based on results[ ]  Customer uses results in day to day diabetes management |
| **Comments or recommendations regarding Monitoring?**       |
| **Taking Medication (VR and OIB)**    |
| **List of current medications**  |
|  | **Medication** | **Dosage** | **Frequency** | **Condition** |
| 1. |       |       |       |       |
| 2. |       |       |       |       |
| 3. |       |       |       |       |
| 4. |       |       |       |       |
| 5. |       |       |       |       |
| 6. |       |       |       |       |
| 7. |       |       |       |       |
| 8. |       |       |       |       |
| 9. |       |       |       |       |
| 10. |       |       |       |       |
| 11. |       |       |       |       |
| 12. |       |       |       |       |
| **List any allergies (food or drug):**      |
| **How is insulin or injectable medication drawn and administered?** [ ]  Independently without assistive devices [ ]  Independently using assistive device (describe in comments) [ ]  Support person assists in insulin administration [ ]  Customer does not take insulin or other injectable |
| **Does the customer verbalize information about insulin?** [ ]  Customer verbalizes how to draw and administer, appropriate storage and travel[ ]  Customer verbalizes appropriate injection sites and proper site rotation[ ]  Customer verbalizes onset, peak, and duration [ ]  Customer needs full training on insulin |
| **Is the customer able to manage other medications?** [ ]  Customer has an organized method for storing and managing medications[ ]  Customer needs instruction on storing and managing medication[ ]  Customer uses vitamins and other alternative medicine (describe in comments) [ ]  Customer is able to manage other medications |
| **The customer:** [ ]  Knows the purpose of his or her medications and how it works[ ]  Takes medications as recommended[ ]  Knows when to notify the doctor and knows what to ask when prescribed a new medication[ ]  Customer needs training on medication(s). |
| **Comments and recommendation regarding taking medication:**      |
| **Healthy Coping (VR and OIB)** |
| **How does the customer feel about having diabetes?** [ ]  Customer is in charge of the diabetes [ ]  Customer doesn’t like it, but does the self-care tasks anyway[ ]  Customer tries to manage it, but feels there is not much he or she can do[ ]  Diabetes is in charge of customer |
| **Does the customer have a support system?** [ ]  Family and friends are physically and emotionally available to help customer[ ]  Family and friends help customer in ways that the customer is resistant to receive[ ]  There are family and friends available, but they have given up on helping customer[ ]  Customer has no support system |
| **Does the customer have any issues regarding depression and diabetes?** [ ]  Customer feels hopeful about the future and diabetes is manageable[ ]  Customer has minor symptoms such as occasional blues, fearfulness, and sleeplessness[ ]  Customer is okay right now but has been depressed in the past and is concerned about depression returning[ ]  Customer is currently depressed and finds it difficult to deal with diabetes and other health issues |
| **What does the customer do to manage stress?** [ ]  Customer is not familiar with stress management techniques[ ]  Customer uses prayer, deep breathing exercises, affirmations, etc.[ ]  Customer has a strong support system[ ]  Customer uses exercise and/or other active techniques |
| **What help would the customer like regarding healthy coping?** [ ]  Books, audio, website, and community resource recommendations[ ]  Help with “diabetes police” and other caregiver concerns[ ]  Help dealing with depression and diabetes issues[ ]  Customer declines assistance with healthy coping |
| **Comments and recommendations regarding healthy coping:**      |
| **Problem Solving (VR and OIB)**    |
| **What does the customer know about hypoglycemia?** [ ]  Customer can verbalize the signs and symptoms and his or her personal response[ ]  Customer can verbalize appropriate treatment[ ]  Customer can verbalize a plan should hypoglycemia happen at work[ ]  Customer needs training on hypoglycemia |
| **What does the customer know about hyperglycemia?** [ ]  Customer can verbalize the signs and symptoms and his or her personal response[ ]  Customer can verbalize appropriate treatment[ ]  Customer can verbalize a plan should hyperglycemia happen at work[ ]  Customer needs training on hyperglycemia |
| **What does the customer know about sick days?** [ ]  Customer understands the importance of monitoring, taking medication, eating, and staying hydrated[ ]  Customer has a sick day kit put together with cold medicines and other things needed to manage when he or she is sick[ ]  Customer can verbalize when to call the doctor[ ]  Customer needs education on managing sick days |
| **The customer is able to:** [ ]  Perform a foot examination and verbalize appropriate skin and wound care[ ]  Verbalize the importance of wearing medical identification[ ]  Choose appropriate clothing, shoes and socks that are not binding[ ]  Customer needs training on foot and skin care. |
| **Comments and recommendations regarding problem solving:**      |
| **Reducing Risk (VR and OIB)**    |
| **Does the customer participate in risky behaviors?** [ ]  Customer smokes [ ]  Customer has problems with drugs or excessive alcohol usage[ ]  Customer has participated in risky behaviors in the past and needs education about effect on health[ ]  Customer does not smoke, drink excessively or have problems with drugs |
| **Does the customer understand the consequences of diabetes mismanagement?** [ ]  Cardiovascular risk including stroke [ ]  Neuropathy and amputation risks [ ]  Kidney disease risk[ ]  Dental disease risk [ ]  Customer needs training on risks of diabetes mismanagement. |
| **Does the customer participate in regularly scheduled healthcare?** [ ]  Regular doctor’s visits including a discussion of laboratory values for diabetes risk factors and immunizations[ ]  Annual eye exams (minimum) [ ]  Annual dental exams [ ]  Foot exams by a professional[ ]  Customer does not participate in scheduled healthcare (describe in comments) |
| **Comments and recommendations regarding reducing risk:**      |
| **Overall Recommendations**   |
| **Recommended Diabetes Education Plan**    |
| **Topic** | **Number of Minutes** | **Key Education Needed** |
| Vocational Rehabilitation |       |       |
| Healthy Eating |       |       |
| Being Active |       |       |
| Monitoring |       |       |
| Taking Medication |       |       |
| Healthy Coping |       |       |
| Problem Solving |       |       |
| Reducing Risk |       |       |
| **Total Minutes Recommended**:      | **Total Hours Recommended:**      |
| **Total number of hours is the anticipated time training will take. A one hour post training assessment should be conducted at least 30 days after the final training session.**  |
| **The Diabetes Education Plan described above will address the following cultural influences:** [ ]  Race [ ]  Gender [ ]  Ethnicity [ ]  Culture[ ]  Religion/Spirituality [ ]  Socioeconomic Status [ ]  Disability[ ]  Person/family-centered beliefs [ ]  Language [ ]  Health Beliefs [ ]  Work culture |
| **Equipment Recommendations**   |
| **Blood Glucose monitoring?** [ ]  Prodigy Voice[ ]  Prodigy Auto code (for Spanish, French, or Arabic speaking customers only)[ ]  Other meter: Other meter Recommendation:      Disability:      Number of additional test strips to include (200 is standard):      [ ]  200 Lancets |
| **Insulin Delivery** [ ]  Count a Dose [ ]  Magniguide |
| **Other Devices** [ ]  Blood Pressure Monitor: [ ]  Medium Cuff [ ]  Large Cuff [ ]  Talking[ ]  Body weight scale [ ]  Talking Body weight scale [ ]  Diabetes Socks: Size:      [ ]  Medical ID[ ]  Pill organizer[ ]  Meal Measure |
| **Other equipment or special needs (describe):**      |
| **Describe customer’s commitment to use equipment above (if provided):**       |
| **Disability Services**     |
| **Due to the customer’s disability, they have difficulty with the following which impacts their diabetes self-management:**  [ ]  Cooking skills: stovetop, microwave, oven, crock pot, George Foreman grill[ ]  Adaptive kitchen tools, including timers[ ]  Kitchen and meal organization, labeling, marking[ ]  Following directions on recipes[ ]  Grocery shopping, including identifying healthy foods and food freshness and purchasing diabetes management supplies [ ]  Record keeping (glucose results log, medication list, important phone numbers)[ ]  Medication labeling, marking, identifying, and organizational techniques and methods[ ]  Setting reminders for medication or other health activities[ ]  Being active without vision (O&M)[ ]  Being active due to disability (Recreation) |
| **Additional comments regarding impact of disability and diabetes self-management:**      |
| **Customer’s Learning Style**   |
| **Instructional method recommended**:  [ ]  Individualized training [ ]  Group training [ ]  Combination |
| **Learning barriers:**[ ]  Auditory [ ]  Visual [ ]  Literacy or numeracy [ ]  Decreased hand sensation[ ]  Cognition/Memory [ ]  Other (specify):       |
| **Highest level of education:**       |
| **Primary language:**  [ ]  English [ ]  Spanish [ ]  Other (specify):       |
| **Customer will work on this behavior change goal until our next visit (customer’s actions until next visit):**      |
| **Observations, comments, and recommendations not covered previously:**      |
| **Start time of visit:**       | **End time of visit:**       |
| **Date of assessment:**       | **Total hours for assessment:**       |

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| **Provider Signatures**  |
| **Diabetes Educator Signature (Required for all providers)** |
| **By signing below, I certify that:*** the above dates, times, and services are accurate;
* I personally facilitated all training, meeting all outcomes required for payment and documented the service, as prescribed in the VR-SFP and service authorization;
* Verification of the customer’s satisfaction and service delivery obtained as stated above;
* I maintain the staff qualifications required for a Diabetes Educator as described in the VR‑SFP or Service Authorization; and
* I signed my signature and entered the date below.
 |
| **Typed or Printed name**:      | **Signature:** (See VR-SFP 3 on Signatures)**X** | **Date Signed**:      |
| **Director** (only required for Traditional-Bilateral Contractors)   |
| **By signing below, I, the Director, certify that:** * I ensure that the services were provided by qualified staff, met all outcomes required for payment, and services were documented, as prescribed in the VR-SFP and service authorization;
* I maintain UNTWISE Director credential, as prescribed in VR-SFP;
* I signed my signature and entered the date below.
 |
| **Typed or Printed name**:      | **Signature:** (See VR-SFP 3 Signatures)**X** | **Date Signed**:      |
| **Select all that apply:** [ ]  UNTWISE Credentialed with ID:       [ ]  VR3490-Waiver Proof Attached |
| **VRS Use Only**  |
| If any question below is answered no or if the report or supporting documentation is missing or incomplete, return the invoice to the provider with the VR3460. Make a case note to document the results of the review and the date VR3460 was sent to provider, when applicable.     |
| **Technical Review to Verify Provider Qualifications**(Completed by any VR staff such as RA, CSC, VR Counselor)   |
| **Director’s Credential:**   |
| UNTWISE website or attached VR3490 verifies, for the dates of service, the director listed above:  [ ]  maintained or waived the UNTWISE Director Credential [ ]  did **not** hold a valid UNTWISE Director Credential |
| **Verification of Service Delivery**  |
| **Technical Review** (completed by any VR staff such as RA, CSC, VR Counselor)   |
| Verified that the report is accurately completed per form instructions | [ ]  Yes [ ]  No |
| Verified that the service(s) was provided within service date of SA and as stated in the VR Standards for Providers and/or the SA | [ ]  Yes [ ]  No |
| When applicable, verify a copy of an approved VR3472 is attached to the report? | [ ]  NA  | [ ]  Yes [ ]  No |
| Verified that this individual session was held for two hours.  | [ ]  Yes [ ]  No |
| Verified that the form was submitted to VRS within 35 days of completion.  | [ ]  Yes [ ]  No |
| Verified that the appropriate fee(s) was invoiced | [ ]  Yes [ ]  No |
| **Printed name of VR staff member making verification:**  |
| 1.        | Date:       | 2.        | Date:       |
| **VR Counselor Review**  |
| Verified that the form reports the information the Diabetes Educator captured during the initial assessment as well as their recommendations for equipment and training.    | [ ]  Yes [ ]  No |
| **By typing or printing your name, the VRC verifies:** * completion of the technical review,
* services provided met the customer’s individual needs,
* services provided met specifications in the VR-SFP and on the SA, and
* customer’s or legally authorized representative’s satisfaction with services received.

[ ]  **Approve to pay invoice** [ ]  **Do not approve to pay invoice** |
| **VR Counselor:**        | **Date:**       |