

UNIT NUMBER

PT. NAME

BIRTHDATE

ADULT DIABETES MELLITUS TEACHING RECORD

Instructions: Check box when patient understands the content presented. Date and sign at bottom of form. Document problems/issues with learning on the Pediatric Flowsheet or Progress Notes. Patient/Family signs when form complete.

LOCATION

DATE

1. Health Management

a. I have received the following educational materials

- Caring for Your Diabetes*
- Starter Kit*
- Diabetes Discharge Information*

b. I can demonstrate:

	R/N demo	PT / Family Demo	Needs Reinforcement	Independent	Date
	Date	Date	Date	Date	Date
insulin injection with syringe, with insulin pen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
insulin injection sites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
insulin withdrawal from vial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
insulin plan dosing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
blood glucose monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ketone testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
glucagon administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
safe syringe/lancet disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
signs/symptoms/treatment of high and low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

c. Check and keep a record of blood sugars before meals and at bedtime

- Keep a food record _____
- Check for ketones when the blood sugar is over 240 mg/dl or when ill.

d. Follow insulin/diabetes pill regimen _____

2. Nutrition

I have received dietary instruction on carb control, no liquid sugar _____

- I can identify carbohydrate food groups and action on blood sugar.

3. Precautions

Call _____ *name* _____ *telephone* for the following:

- blood sugar less than 70, greater than 400.
- positive urine ketones
- low blood sugar requiring glucagon administration
- no smoking; referral to smoking cessation clinic 1-800-No Butts

4. Additional Instructions / Information

- Contact the Diabetes Teaching Center (415) 353-2266

- Schedule appointment at UCSF Diabetes Clinic (415) 353-2497

Patient/Family Signature: _____ Date: _____

- Translator used for instructions

Instructor Signature: _____ *name* _____ *title* _____ *date*

_____ *name* _____ *title* _____ *date*

_____ *name* _____ *title* _____ *date*

_____ *name* _____ *title* _____ *date*

602-549 (Rev: 12/06) WorkflowOne ORIGINAL - MEDICAL RECORD COPY YELLOW - PATIENT/FAMILY COPY