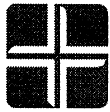


UnityPoint Clinic

1002 4TH AVE SE
CEDAR RAPIDS, IA 52403
PHONE (319) 298-2200
FAX (319) 298-2296

Welcome to UnityPoint Clinic's Diabetes Education,

This letter and the following packet of information will help prepare you for your visit to our center. Please read these items carefully and follow the instructions given.

(Please arrive 10-15 minutes before your scheduled appointment time.)

What do I need to bring to my first appointment?

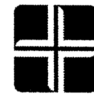
- **Insurance Card(s), Photo ID**
- **Completed Adult Diabetes History form** enclosed with this letter.
- **Completed Food Record** section is very important for the dietitian.
- **Current list of your medicines** (include name of drug, dose, and time of day taken).
- **If you already have a blood glucose meter:** please bring the meter, test strips, quality control solution for your meter, your meter instruction book and blood sugar records.
- **If you do not have a blood glucose meter, one can be provided for you**.
  - Check with your insurance company prior to your appointment. See sheet on insurance coverage for questions to ask your insurance company.
- **Calendar/Appointment Book**
  - Additional visits will be scheduled at your first appointment.

Where do I go?

- UnityPoint Clinic, Diabetes & Kidney Center
  1002 4th Ave SE, Cedar Rapids, IA 52403
- Parking: You may park in the lot next to the building.
- Entrance: Please use the 4th Ave side entrance.
- Check in at the reception desk when you arrive.

If you need to change your appointment, call **(319) 298-2200**.

Adult Assessment Form



Name: ______________________

Email address: ______________________

Birth date: ________ **Today's Date:** __________

Race: (Check all that apply)
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Hawaiian or Other Pacific Islander
- ☐ Hispanic/Latino/Chicano
- ☐ Mexican/Puerto Rican
- ☐ Middle Eastern
- ☐ Other ______________
- ☐ Unknown

Preferred Language:
- ☐ English ☐ Spanish
- ☐ Other ______________

Do you work outside the home? ☐ Yes ☐ No
Physically active job? ☐ Yes ☐ No
Type of work? ______________
What shift? ______________

Do you have any special learning needs or limitations? (Check all that apply)
- ☐ Vision concerns
- ☐ Hearing concerns
- ☐ Reading concerns
- ☐ Understanding English
- ☐ Remembering what I learn
- ☐ Eating foods from my own culture or religion
- ☐ Exercise limitations
- ☐ Physical Difficulty
- ☐ Writing
- ☐ Other, please explain: ______________

Do you learn best by: (Check all that apply)
- ☐ Hearing
- ☐ Touching (Doing)
- ☐ Seeing
- ☐ Reading

Emotional and Social Concerns:

How long have you had diabetes? __________

Have you had any previous diabetes education? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No
Type: ______________
How often? ______________
How many minutes per day? ______________

How many meals do you eat per day? ________

How many times do you snack per day? ______

Are you following a special diet?
☐ Yes ☐ No: What type: ______________?
What percent of the time do you follow your special diet? ______________

Who does the cooking in your house?
☐ Self ☐ Spouse ☐ other: ______________
How often do you eat out? ______________
(if you eat out less than once per week, please enter 0)

Have you experienced in the last 4 weeks? (Check all that apply)

☐ Change in appetite	☐ Chewing problems
☐ Heartburn	☐ Constipation
☐ Nausea	☐ Diarrhea
☐ Vomiting	☐ Weight loss
☐ Swallowing problems	☐ Weight gain

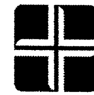
Do you check your blood sugar? ☐ Yes ☐ No
How many times per day do you check? ________
What time(s) of day do you check your sugar?
____

Have you visited a hospital emergency department in the last 12 months?
☐ No ☐ Not sure ☐ Yes: Reason: ________
____

Have you been hospitalized in the last 12 months?
☐ No ☐ Yes: Reason: ______________

(PATIENT LABEL)

Adult Assessment Form



Do you have financial concerns and/or difficulty paying for your medications? ☐ No ☐ Yes
Are you currently in a relationship in which you feel unsafe or threatened? ☐ No ☐ Yes
Are you experiencing any changes or problems in relationships with others? ☐ No ☐ Yes

Directions: Living with diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are 2 potential problem areas that people with diabetes may experience. Consider the degree to which each of the 2 items may have distressed or bothered you

DURING THE PAST MONTH and circle the appropriate number.
Please note that we are asking you to indicate the degree to which each item may be bothering you in your life, NOT whether the item is merely true for you. If you feel that a particular item is not a bother or a problem for you, you would circle "1." If it is very bothersome to you, you might circle "6."

	Not a Problem		Moderate Problem		Serious Problem	
1. Feeling overwhelmed by the demands of living with diabetes.	1	2	3	4	5	6
2. Feeling that I am often failing with my diabetes regimen.	1	2	3	4	5	6

What is your biggest concern in managing your diabetes?________________________________
____
____

Who do you live with?
☐ Live alone ☐ With spouse or partner ☐ With spouse/partner and children
☐ With children only ☐ With parents only ☐ With other family member or friends
☐ Other: ________________________________

Who helps you with your diabetes?
☐ Self ☐ Spouse ☐ Child ☐ Non-Relative ☐ Other________________

Planning a pregnancy in the next 12 months? ☐ No ☐ Not sure ☐ Yes

Foot exam by a provider in the last 12 months? ☐ No ☐ Yes: Date: ________

Do you check your feet daily? ☐ No ☐ Yes

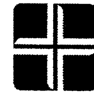
Dilated eye exam in the last 12 months? ☐ No ☐ Not sure ☐ Yes: Date: ________

Dental exam in the last 6 months? ☐ No ☐ Not sure ☐ Yes: Date: ________

Hemoglobin A1C in the last 3-6 months? ☐ No ☐ Not sure ☐ Yes
Results? __________ Date: ______________

(PATIENT LABEL)

Adult Assessment Form


UnityPoint Clinic

Cholesterol or lipid test in the last 12 months? ☐ No ☐ Not sure ☐ Yes:
Results? ______________________

Flu vaccine in the last 12 months? ☐ No ☐ Not sure ☐ Yes

Pneumonia vaccine in the past 5 years? ☐ No ☐ Not sure ☐ Yes

Do you have any of the following health concerns?

High blood sugars ☐ No ☐ Yes: How many times per week? ____________
Low blood sugar reactions ☐ No ☐ Yes: How many times per week? ____________
What do you do when you have a low blood sugar? ____________
Allergies ☐ No ☐ Yes: To what? ____________
Thyroid disease ☐ No ☐ Yes
Heart disease ☐ No ☐ Yes
Heart attack ☐ No ☐ Yes
Stroke ☐ No ☐ Yes
High blood pressure ☐ No ☐ Yes
High cholesterol ☐ No ☐ Yes
Eye or vision ☐ No ☐ Yes
Intestinal or stomach ☐ No ☐ Yes: Please explain: ____________
Kidney problems ☐ No ☐ Yes
Liver problems ☐ No ☐ Yes
Foot problems ☐ No ☐ Yes
Circulation Problems ☐ No ☐ Yes
Amputation ☐ No ☐ Yes
Anxiety ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Sexual function problem ☐ No ☐ Yes
Tobacco use ☐ No ☐ Yes: Amount per day: ____________
Would you like assistance to quit using tobacco? ☐ No ☐ Yes
Alcohol use ☐ No ☐ Yes: Amount per day: ____________
Does alcohol interfere with your life in any way? ☐ No ☐ Yes
Would you like assistance limiting alcohol? ☐ No ☐ Yes
Pain ☐ No ☐ Yes: Where is your pain? ____________
Please rate your pain intensity by circling one:
(1=mild) 1 2 3 4 5 6 7 8 9 10 (10=unbearable)
Would you like assistance with pain relief? ☐ No ☐ Yes
Other medical conditions? ☐ No ☐ Yes: Please list ____________

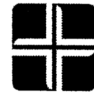
____

☐ See medication list enclosed for medications

☐ See EPIC Prior to Arrival (PTA) medication list for medications

(PATIENT LABEL)

Adult Assessment Form


UnityPoint Clinic

Please fill this out and bring to your appointment or bring another list of your medications or your medication bottles.

Diabetes medicines:

Name: ______________________ Dose: ________ Usual time(s) you take it: ____________

Name: ______________________ Dose: ________Times________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Other medicines, herbs, vitamins, supplements:

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

Name: ______________________ Dose: ________Times ________________________

(PATIENT LABEL)

Adult Assessment Form

UnityPoint Clinic

TYPICAL FOOD INTAKE

1. Please fill in the usual time that you eat your meals and snacks. If you do not eat a meal or snack at a certain time, write none.
2. List the foods and beverages you would consume in a typical day.
3. Write down the amount of each food/beverage you consume.

	Time:	Foods and Beverages:	Food Amount:
1st meal of the day:			
Snack			
2nd meal of the day:			
Snack			
3rd meal of the day:			
Snack			

List any foods that you do not eat (i.e. food allergies or religious restrictions): ____________________

____

(PATIENT LABEL)

Diabetes Education

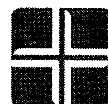
is now located in the Diabetes & Kidney Center

Please note our new phone number & address

1002 4th Ave. SE | Cedar Rapids, IA 52403 Phone: (319) 298-2200

380
151
Coe Rd NE
St. Luke's Hospital
A Ave
1st Ave
12th St SE
10th St SE
4th Ave SE
7th St SE
8th St SE
UnityPoint Clinic
Diabetes and Kidney Center

unitypoint.org



UnityPoint Clinic

UnityPoint Clinic

1002 4TH AVE SE
CEDAR RAPIDS, IA 52403
PHONE (319) 298-2200
FAX (319) 298-2296

INSURANCE COVERAGE

Insurance coverage for diabetes education services can vary. It is your responsibility to call your insurance company to see what they cover. A checklist is provided to help you ask the right questions.

QUESTIONS TO ASK YOUR INSURANCE COMPANY

If you do not have insurance coverage available, UnityPoint Clinic may be able to help.

Please feel free to call the following:

- UnityPoint Clinic's Financial Assistance (888) 343-4165

Insurance companies that provide coverage for **diabetes self-management training** (diabetes education) require the program to have ADA (American Diabetes Association) recognition status. UnityPoint Clinic's Diabetes Education is an ADA Recognized and State Certified Program.

Ask your insurance company the following questions:

1) Is diabetes self-management training covered? ______________________
    - How many hours of initial education are covered? ______________________

      If you are limited to a certain number of visits, please contact us as we may need to reschedule your first appointment.
    - Is there a specific time period in which the education must be completed? __________
    - How many hours of annual follow-up education is covered? ______________

2) You can receive a blood glucose meter at your first appointment if you do not already have one. **If you have a meter, please bring it to your first appointment.**

   Ask your insurance company what your co-pay is for each of the following brands of test strips.

   - ☐ Freestyle (Abbott)
   - ☐ Contour (Ascensia)
   - ☐ One Touch (LifeScan)
   - ☐ Accu-Chek (Roche)

3) Are there specific places from which you must order your supplies?

   ____