



# Mary Washington Healthcare

Thank you for choosing Mary Washington Hospital Diabetes Self-Management Education and Support Services located in Cosner's Corner Office Park, 4710 Spotsylvania Parkway, Suite 200, Fredericksburg, VA 22407.

Please arrive 10 minutes prior to your initial appointment.

\*We request a minimum of 24-hour notice if you must cancel or reschedule your appointment.

Please fill out the Health History form in this packet and bring it to your first appointment.

As a courtesy, Mary Washington Hospital will bill your insurance company for your diabetes education.

## **We request that you:**

- Bring your completed Health History form.
- Be prepared to show your insurance card.
- Bring your blood sugar meter and logbook if you currently are checking your blood sugars. You do not need to buy a meter if you do not already have one. We will assist you with that process.
- Please feel free to bring a guest (spouse, friend, family member).
- Remember there is no need to fast before this appointment.

Our health care team of diabetes experts is committed to helping you and your family develop the skills, knowledge and confidence to control diabetes. Mary Washington Hospital Diabetes Self-Management Education and Support Services has earned the American Diabetes Association Recognition for quality patient education. Directions to our office are included in this packet.

If you have any questions, please feel free to contact us at 540.741.2210.

Cathy Peterjohn, MS, RD, CDE  
Program Manager

## **Our Educators:**

Joanne Fortune, MS, RD, CDE  
Stefanie Rekdal, RD, CDE, CPT  
Laura Eubanks, RD, CDE, CPT

Parminder Singh, BSN, RN, CDE  
Violet Jones, MS, RD, CDE  
Jody Long, MS, RD  
Maria Taeza-Pedroza, BSN, RN

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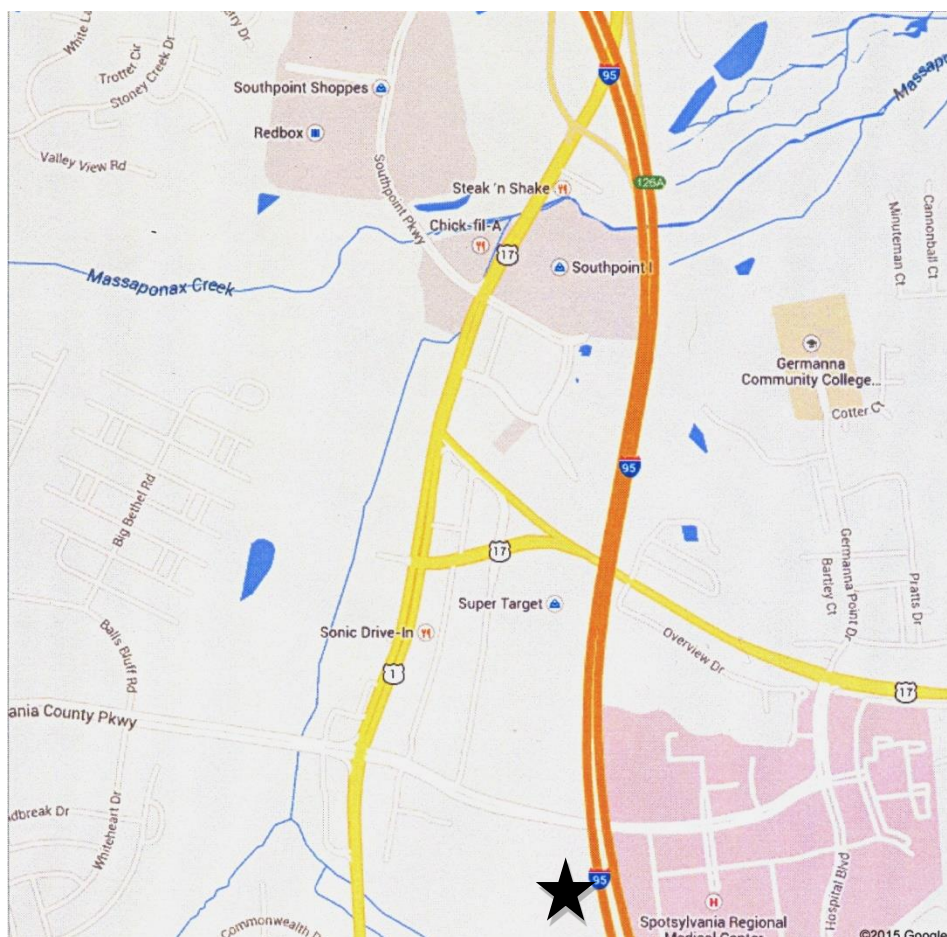
# Directions to: Diabetes Management

4710 Spotsylvania Parkway, Suite 200  
Fredericksburg, VA, 22407  
540.741.2210

**From Interstate 95 South**, take exit 126-Spotsylvania, Turn right onto Route 1 South. Go approximately 1 mile. Turn left onto Spotsylvania Parkway (there will be a CVS on your right-hand side). Go approximately 0.4 mile. Our location will be on your right-hand side immediately after you pass Jo-Ann Fabrics and Craft store. Look for Cosner's Corner Office Park. Come around to the front of the building. We are located on 2<sup>nd</sup> floor, turning right and right again after elevator

**From Interstate 95 North**, take exit 126 B onto Rt 1 South. Follow directions listed above.

**From Rt VA 2/US 17 (New Post)** Take US 17 N towards Rt 1, drive 5 miles. Turn left onto Hospital Boulevard, drive 0.2 miles. Turn right onto Spotsylvania Parkway. Cross over I-95 and make a U-turn. Our location will be on your right-hand side immediately after you pass Jo-Ann Fabrics and Craft store. Look for Cosner's Corner Office Park. Come around to the front of the building. We are located on 2<sup>nd</sup> floor, turning right and right again after elevator.



**INSTRUCTIONS**

Please provide the information requested to help us serve you better. You may leave blank any areas of which you are uncertain, and the Diabetes Educator will review the information with you during your session.

***To BE COMPLETED BY PATIENT.*****DEMOGRAPHIC INFORMATION**

NAME	EMAIL ADDRESS	CURRENT DATE
PREFERRED PHONE #	DATE OF BIRTH	NAME OF REFERRING PHYSICIAN

**GENERAL MEDICAL INFORMATION**

IF YOU HAVE ANY FOOD ALLERGIES, PLEASE LIST THEM:

PLEASE LIST ANY CHRONIC ILLNESS AND DATE OF DIAGNOSIS

PLEASE LIST DATE/TYPE OF PAST SURGERIES.

PRESCRIBED DIABETES MEDICATIONS BY MD

OVER THE COUNTER SUPPLEMENTS (i.e. vitamins, herbals, etc.)

HIGH BLOOD PRESSURE  YES  NO

***NUTRITION HISTORY: PLEASE WRITE WHAT YOU EAT AND DRINK ON A TYPICAL DAY.***

BREAKFAST (TIME)

LUNCH (TIME)

DINNER (TIME)

SNACK (A.M.)

SNACK (P.M.)

SNACK (BEDTIME)



Mary Washington Healthcare

PATIENT IDENTIFICATION

1 1/4" X 3"

**Outpatient Diabetes Management Record**  
**(Pregnant Patient)**

FR-1184A-MWHC- Rev. 8/2018

**Diabetes History** **To Be Completed By Patient (pg. 2)**

<input type="checkbox"/> Type 1	Gestational	Length of time since diagnosis	If recently, signs and symptoms	
<input type="checkbox"/> Type 2	Other			
Treatment <input type="checkbox"/> Diet/Exercise <input type="checkbox"/> Oral (pills) <input type="checkbox"/> Insulin		Name of insulin or oral drug	Dose	Side Effects
Monitor Blood Sugar? Yes No	Which meter?	How often/time of day?	Usual readings	Do you record results? Yes No
Do you have family history of diabetes? Mother Father Sibling Other		Time lost from work or school in the past year due to diabetes? Yes No How many days?		

**Pain Assessment**

Do you have any chronic pain? Yes No	If yes, where located?	Duration of pain?	Any treatment?
How would you rate the pain? 1 2 3 4 5 6 7 8 9 10 (10 is the worst and 1 is the least) Describe:			

**Physical Activity Habits**

Any restrictions for activity by MD: Yes No	Regular exercise program: Yes No	Type and Duration:
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**Education History**

Level of Education Grade School High School College	Problems with learning? Yes No	If yes, describe
Have you had any diabetes education before? Yes No	If yes, when and where?	Did friend/family participate? Yes No

**Social History**

Do you smoke? Yes No	Do you drink alcohol? Yes No
Do you have an eating disorder? Yes No	If yes, is your physician aware? Yes No
Do you use community resources? (example -Health Department, Rappahannock Community Services Board)? Yes No If yes, which ones?	
How many people live in your home?	What are their relationships to you?

**Hygiene Patterns**

Do you see a dentist once per year? Yes No	Do you see an eye doctor once a year? Yes No
Do you practice some form of contraception when not pregnant? Yes No	

**Health Belief/Goals/Attitudes**

Feelings about your health and diabetes?  
Areas of interest/concern for education session?

**TO BE COMPLETED BY DIABETES EDUCATOR**

HEIGHT	WEIGHT	PRE-PREGNANCY WT	EDC	<input type="checkbox"/> SINGLE BIRTH <input type="checkbox"/> MULTIPLE BIRTH
PAST HISTORY OF GESTATIONAL DIABETES: <input type="checkbox"/> YES <input type="checkbox"/> NO	DELIVERY GOALS: <input type="checkbox"/> NATURAL BIRTH <input type="checkbox"/> MEDICATION POST PARTUM GOALS: <input type="checkbox"/> BREASTFEED <input type="checkbox"/> BOTTLEFEED <input type="checkbox"/> COMBINATION	CHILD #1 BIRTH WT	CHILD #2 BIRTH WT	CHILD #3 BIRTH WT _____
		<input type="checkbox"/> C-SECTION <input type="checkbox"/> VAGINAL	<input type="checkbox"/> C-SECTION <input type="checkbox"/> VAGINAL	<input type="checkbox"/> C-SECTION <input type="checkbox"/> VAGINAL
GRAVIDA/PARA _____/____	COMMENTS:			

Signature of Diabetes Educator	Date/Time
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PATIENT IDENTIFICATION  
1 1/4" X 3"