



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**

<b>Customer name:</b>	<b>TWS-VRS Case ID:</b>
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<b>Referral date:</b>	<b>Counselor name:</b>	<b>Service authorization number:</b>
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**Customer Demographics**

<b>Age:</b>	<b>Sex:</b> (check box): M    F	<b>Marital status:</b> Married    Divorced    Single    Widowed	<b>Number in household</b> (including customer):
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**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**

<b>Primary support person and relationship:</b>	<b>Telephone number:</b> (    )
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**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    No  
If 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

<b>Current meter:</b>			<b>Frequency of testing:</b>		
<b>Current blood glucose reading:</b> Premeal                  Post meal Date:                      Time:                      Result:			<b>Does the customer know his or her most recent A1c?</b> Yes      No      Result:		
Does the customer:	<input type="checkbox"/> Understand how to use the meter and get a drop of blood to the test strip	<input type="checkbox"/> Show willingness to monitor his or her blood sugar?	<input type="checkbox"/> Need education or motivation to monitor	<input type="checkbox"/> 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		
<b>Total Minutes Recommended:</b>		<b>Total Hours Recommended:</b>
<b>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.</b>		
<b>The Diabetes Education Plan described above will address the following cultural influences:</b>		
<input type="checkbox"/> Race	<input type="checkbox"/> Gender	<input type="checkbox"/> Ethnicity
<input type="checkbox"/> Religion/Spirituality	<input type="checkbox"/> Socioeconomic Status	<input type="checkbox"/> Culture
<input type="checkbox"/> Person/family-centered beliefs	<input type="checkbox"/> Language	<input type="checkbox"/> Disability
		<input type="checkbox"/> Health Beliefs
		<input type="checkbox"/> Work culture
<b>Equipment Recommendations</b>		
<b>Blood Glucose monitoring?</b>		
<input type="checkbox"/> Prodigy Voice		
<input type="checkbox"/> Prodigy Auto code (for Spanish, French, or Arabic speaking customers only)		
<input type="checkbox"/> Other meter: Other meter Recommendation:		
Disability:		
Number of additional test strips to include (200 is standard):		
<input type="checkbox"/> 200 Lancets		
<b>Insulin Delivery</b>		
<input type="checkbox"/> Count a Dose		
<input type="checkbox"/> Magniguide		
<b>Other Devices</b>		
<input type="checkbox"/> Blood Pressure Monitor: <input type="checkbox"/> Medium Cuff <input type="checkbox"/> Large Cuff <input type="checkbox"/> Talking		
<input type="checkbox"/> Body weight scale <input type="checkbox"/> Talking Body weight scale		
<input type="checkbox"/> Diabetes Socks: Size:		
<input type="checkbox"/> Medical ID		
<input type="checkbox"/> Pill organizer		
<input type="checkbox"/> Meal Measure		
<b>Other equipment or special needs (describe):</b>		
<b>Describe customer's commitment to use equipment above (if provided):</b>		

**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:**

## 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.

<b>Typed or Printed name:</b>	<b>Signature:</b> (See VR-SFP 3 on Signatures)	<b>Date Signed:</b>
	<b>X</b>	

### 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.

<b>Typed or Printed name:</b>	<b>Signature:</b> (See VR-SFP 3 Signatures)	<b>Date Signed:</b>
	<b>X</b>	

- 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
<b>Printed name of VR staff member making verification:</b>			
1.	Date:	2.	Date:
<b>VR Counselor Review</b>			
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
<b>By typing or printing your name, the VRC verifies:</b>			
<ul style="list-style-type: none"> <li>• completion of the technical review,</li> <li>• services provided met the customer's individual needs,</li> <li>• services provided met specifications in the VR-SFP and on the SA, and</li> <li>• customer's or legally authorized representative's satisfaction with services received.</li> </ul>			
<b>Approve to pay invoice</b>		<b>Do not approve to pay invoice</b>	
<b>VR Counselor:</b>			<b>Date:</b>