ASSESSMENT FORM FOR DIABETES MELLITUS PATIENTS ON INSULIN

Sivam Diabetes & Primary Care LLC
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Checking Your Insurance Benefits

IMPORTANT

Please check your insurance coverage for your **Primary Care Provider** (PCP) prior to any visit for Primary Care, Nutrition (Medical Nutrition Therapy) or Diabetes Education appointment at SIVAM DIABETESTES & PRIMARY CARE LLC. You will be responsible for any services that are not covered. **Call the number on the back of your insurance card** and give them the following information:

1. You are being seen at SIVAM DIABETES & PRIMARY CARE LLC. Our NPI # is 1710525662. Our TAX ID # is 84 2801777. **Your insurance will be located by the provider's name)- Dr. Mavis Ermakov,** DNP, APN, FNP-BC, RD, CDCES
2. You will be billed as *Healthcare Clinic* a healthcare office.
3. **Dr. Mavis Ermakov's NPI** is: 1265614911
4. The **procedure codes** are:
    - **Diabetes Education with a Nurse**
        - **G0108** (Diabetes Education)
    - **Medical Nutrition Therapy with a Registered Dietitian**: (Nutrition Diagnosis **ONLY:** Check the **2 procedure** codes below.)
        - **97802** (Initial Visit)
        - **97803** (Follow Up Visit)

    If you are scheduled with both a nurse and a dietitian, please check all 3 codes.
5. Be sure to ask for the representative's first name and last initial and a **reference number** for the call. **Document the date of the call for your files:**

    _____
6. **Additional questions to ask your insurance company:**
    - Any limitations on visits and how many visits per calendar year are allowed? If visits are limited, are there different limits for the Diabetes Nurse or Diabetes Educator and the Registered Dietitian?
    - **Are Referrals or Pre-Certification required**? If a referral is needed, please call your doctor's office, and bring it with you on the day of your appointment. If you need a Pre- Certification please contact us. **The referral form** can be downloaded from the patient portal.
    - What is your responsibility: co-pay, co-insurance, or deductible?
    - Be sure to ask for the representative's first name and last initial, a reference number for the call and document the date of the call.

If your insurance informs you that our services are **NOT** a covered benefit please call our center so that we may discuss other options or have your insurance company representative contact our office at 973-373-9080.

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PLEASE USE PEN. DO NOT USE PENCIL

Name: _____ **Date**: _____

Primary Care Physician:_____ **Endocrinologist:** _____

☐ Type 1 ☐ Type 2 Age at Diagnosis: _____
years with Diabetes _____

Please describe any diabetes and nutritional education you have received since your diagnosis of diabetes and where it occurred.

_____

Insulin Use:
Please Circle the insulins you currently use:
Long acting: Basaglar Lantus Levemir Toujeo Tresiba NPH
Rapid Acting: Humalog Novolog Apidra Fiasp
Dose of Long Acting and time(s) taken_____
Dose of Rapid Acting Insulin_____
Please list the onset peak and duration of your rapid acting insulin if you know it.
Onset _____ Peak __ Duration_____
How do you determine dose of mealtime insulin?
_____
What is your Insulin: Carb Ratio? _____
What is your Insulin Sensitivity Factor? (also called Correction factor)
_____

Oral Medications:
Please list any oral medications or non-insulin injectable medications that you take for diabetes:_____
_____
_____

Continuous Glucose Monitoring (CGM)/ Glucose Monitoring
Do you wear or have you ever worn a Continuous Glucose Monitor (CGM)? ☐ Yes ☐ No
If yes, which one? _____
If you do not wear a CGM how many times a day do you check your blood sugar?
_____ Which meter do you use? _____

Nutrition
Do you count carbohydrates? ☐ Yes ☐ No

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How would you rate your carb counting ability? ☐ Good ☐ Fair ☐ Poor
Do you eat a high fat diet? ☐ Yes ☐ No ☐ Not Sure
Do you use apps to look up nutritional information? ☐ Yes ☐ No
If yes, which apps do you use? _____
What do you drink with your meals? _____
Do you skip meals? ☐ Yes ☐ No If yes, which meals? _____
How many times a week do you eat away from home?_____
____Fast Food ____Restaurant ____Take Out Other _____

Exercise
Do you Exercise? ☐ Yes ☐ No
What do you do for exercise? _____
How often do you exercise? _____
Do you adjust insulin dose for exercise? ☐ Yes ☐ No
What insulin adjustments do you make?
_____

High Blood Sugar:
What do you do when your blood sugar is high? _____
Do you know what DKA is? ☐ Yes ☐ No
Have you had any episodes of DKA within the last two years? ☐ Yes ☐ No

Low Blood Sugar:
Do you always carry a source of sugar with you? ☐ Yes ☐ No
If yes, what do you carry? _____
Do you get symptoms with low blood sugar? ☐ Yes ☐ No
Do you have a prescription for Glucagon? ☐ Yes ☐ No
Have you ever needed assistance from another person to treat low blood sugar? (Glucagon, call to 911, or assistance getting food/drink) ☐ Yes ☐ No
If yes, please describe
_____
_____

Living and Working Situation:
With whom do you live? ☐ Alone ☐ Spouse ☐ Family ☐ Friend ☐ Significant other
Do you have support in your diabetes management? ☐ Yes ☐ No If yes who:
_____
Are you employed? ☐ Yes ☐ No If yes, type of job:
_____
Are you retired? ☐ Yes ☐ No

Stress Level on a scale of 1-10 (10 = very high) _____

Sleep Problems: ☐ Yes ☐ No If yes, please describe:
_____
_____

Learning Needs: Do you have any problems with hearing, vision, or speech? ☐ Yes ☐ No Explain:
_____
Do you use diabetes, nutrition, or physical activity apps? ☐ Yes ☐ No

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What apps do you use? _____

Feelings and Concerns:

How do you feel about having diabetes? ☐ Okay ☐ Anxious ☐ Angry ☐ Afraid ☐ Sad ☐ Alone ☐ Depressed ☐ Overwhelmed ☐ Burned out ☐ Unsure of what to do Other: _____

Depression:

Have you recently felt down, depressed, hopeless or have little interest in doing things?
☐ Yes ☐ No
Are you being treated for depression? ☐ Yes ☐ No

Pain Assessment:

Do you have a condition that causes chronic pain? ☐ Yes ☐ No

Women's Health:

Are you of childbearing age? ☐ Yes ☐ No. If yes, do you use birth control? ☐ Yes☐ No
Method: _____
Have you had gestational diabetes? ☐ Yes ☐ No

Alcohol/Nicotine:

Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____
What do you drink? ☐ Light Beer ☐ Beer ☐ Wine ☐ Liquor

Do you use any nicotine products? ☐ Yes ☐ No If yes, ☐ Smoke cigarettes ☐ Chew tobacco ☐ Cigars ☐ Pipe ☐ E-Cigarettes How much do you smoke? _____

General Diabetes Information:

Are there any cultural factors that affect your diabetes? ☐ Yes ☐ No If yes, please explain
_____
Have you had any hospitalizations or emergency room visits because of your diabetes within the last two years?
☐ Yes ☐ No If yes, describe_____

Last Dilated eye exam: _____Last Dental Exam _____Last Foot Exam _____

Food Security:

I was worried our food would run out before we got money to buy more:
☐ Often ☐ Sometimes ☐ Never
The food we bought just didn't last and we didn't have money to get more:
☐ Often ☐ Sometimes ☐ Never

Anything else you would like us to know?

_____
_____
_____

Patient Signature: _____ Date: _____

Diabetes Educator Signature: _____ Date: _____

Registered Dietitian Signature: _____ Date: _____

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Nutrition Food Log

Name: _____

Usual Weight: _____ **Goal Weight:** _____ **Recent Gain or Loss:** _____

Please record a "usual" day.
What kind of food? How much food?

BREAKFAST Time _____ **Foods/Amounts**	**MORNING SNACK Time** _____ **Foods/Amounts**
LUNCH Time _____ **Foods/Amounts**	**AFTERNOON SNACK Time** _____ **Foods/Amounts**
DINNER Time _____ **Foods/amounts**	**EVENING SNACK Time** _____ **Foods/Amounts**

_____, CDCES, R.D. Date: _____