



Mary Washington Hospital

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

Please arrive 10 minutes prior to your scheduled time if you are unable to fill out your Health History form prior to your appointment.

*We request a minimum of 24-hour notice if you must cancel or reschedule your appointment. Failure to provide 24-hour notice may result in a no-show fee.

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 (on pages 3–4 of this packet).
- 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.

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

Daniell McKiver
Operations Manager

Our educators:

Stefanie Rekdal, RD, CDCES, CPT
Jody Long, MS, RD, CDCES
Parminder Singh, BSN, RN, CDCES
Courtney Wilkerson, BSN, RN, CDCES
Sarah Whitson, BS, RD, CDCES
Elsa Nicholson, BS, RD

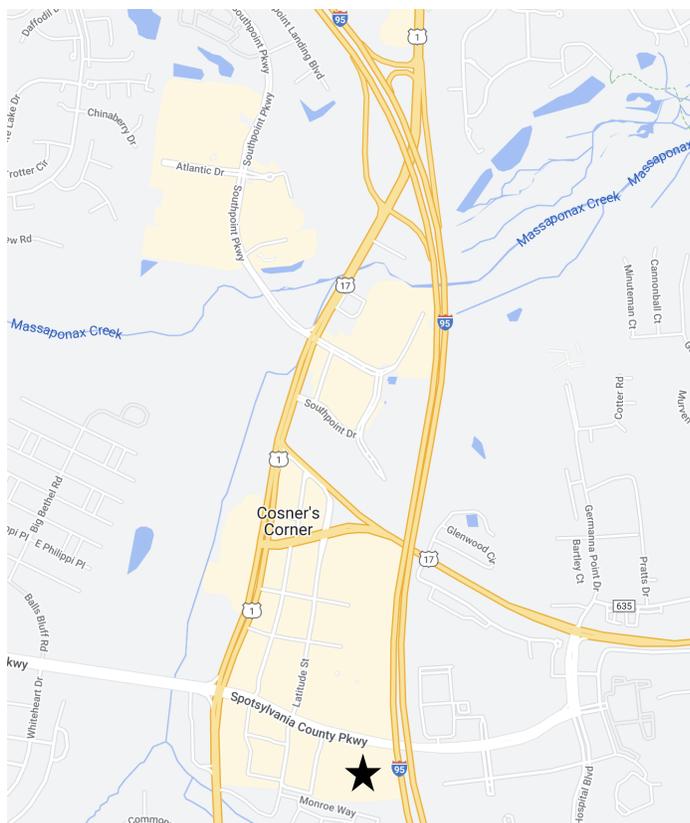
Directions to: Diabetes Management

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 2nd 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 2nd floor, turning right and right again after elevator.



Scan me with your phone camera for
Google maps directions.

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	DATE OF BIRTH	OCCUPATION	CURRENT DATE
PREFERRED PHONE #	EMAIL ADDRESS	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 <input type="checkbox"/> YES <input type="checkbox"/> 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)

Yes/No Within the past 12 months we/I worried whether our food would run out before we got money to buy more.

Yes/No Within the past 12 months the food we/I bought just didn't last and we/I didn't have money to get more.

RN4705



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

FR-1184A-MWHC- Rev. 6/2020

PATIENT IDENTIFICATION
1 1/4" X 3"

Diabetes History					To Be Completed By Patient (pg. 2)				
Type 1 Type 2	Gestational Other	Length of time since diagnosis			If recently, signs and symptoms				
Treatment Diet/Exercise Oral (pills): Please list name(s) and doses _____ Insulin: Please list type(s) and doses _____									
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:				
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? No Yes, when and where?						Did friend/family participate? Yes No			
Social History									
Do you smoke, vape or chew tobacco? 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="radio"/> SINGLE BIRTH <input type="radio"/> MULTIPLE BIRTH	
PAST HISTORY OF GESTATIONAL DIABETES: <input type="radio"/> YES <input type="radio"/> NO GRAVIDA/PARA _____/____		DELIVERY GOALS: <input type="radio"/> NATURAL BIRTH <input type="radio"/> MEDICATION POST PARTUM GOALS: <input type="radio"/> BREASTFEED <input type="radio"/> BOTTLEFEED <input type="radio"/> COMBINATION		CHILD #1 BIRTH WT <input type="radio"/> C-SECTION <input type="radio"/> VAGINAL		CHILD #2 BIRTH WT <input type="radio"/> C-SECTION <input type="radio"/> VAGINAL		CHILD #3 BIRTH WT _____ <input type="radio"/> C-SECTION <input type="radio"/> VAGINAL	
COMMENTS:									
Signature of Diabetes Educator					Date/Time				

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