Diabetes Community Center
TEACHING HEALTH...CREATING HOPE

PUMP/CGM CLIENT REGISTRATION

DATE:_____ EMAIL:_____

Do you give DCC permission to use your email for general communication (you will only see your email address)? Yes No

LAST NAME: _____ **FIRST NAME:** _____**DOB:**_____**AGE:**_____
ADDRESS:_____CITY:_____STATE_____ZIP: _____
PREFERRED CONTACT #:_____ RACE/ETHNICITY:_____
OCCUPATION:_____LEVEL OF EDUCATION:_____
EMERGENCY CONTACT (& title:)_____PHONE: _____
MARITAL STATUS:_____INSURANCE CARRIER:_____

PHYSICIAN INFO: Primary Care:_____Phone:_____
Referring Physician:_____ Phone:_____

MEDICAL INFO: TYPE 1 ☐ TYPE 2 ☐ PRE-DIABETES ☐ GESTATIONAL ☐ OTHER ☐
Date of Diabetes Diagnosis:_____Age at Diagnosis:_____

Monitoring & Medications:
Which blood glucose monitor do you use at home? _____ How often do you self-test? _____
Last Hgb A1C: _____ Date: _____ Do you check for ketones? Yes ___ No___ Any known drug allergies? _____
Insulin type and dose: (please circle type) Current Pump Name and Model:_____
Lantus/Levimir: AM:_____PM:_____
Humalog/Novolog/Apidra: Breakfast:_____ Lunch:_____ Dinner:_____ Other:_____
Insulin to Carb Ratios: _____ Correction Factors: _____
Basals: _____

Complications:
History of DKA?_____
Any hospital-related stays in past year due to diabetes? (Please explain)_____
List current/past complications. _____

Lifestyle Habits:
Do you exercise regularly? Yes _____ No _____ What kind of exercise and duration?_____ Times a week? ____
What is the most difficult part about having diabetes?_____

Teaching Plan:
What is your preferred method of learning? (ex: demonstration, reading, etc): _____
Do you have any barriers to learning? (ex: visual, language, etc): _____
Any additional comments:_____

Patient Signature: _____ **Date:** _____

Diabetes Educator: _____ **Date:**_____