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| --- | --- | --- | --- |
| **My Name:** |  | **Date of Birth** |  |
| **Date Plan Written:** |  | **Date to Review:** |  |
|  |
| **Emergency Contact Details** |
| **Name:** |  |
| **Address:** |  |
| **Home Phone:** |  | **Mobile:** |  |
|  |
| **PEOPLE INVOLVED IN DEVELOPING THE DIABETES HEALTH SUPPORT PLAN** |
| **Name** | **Position** |
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|  |  |
| **DETAILS OF DIABETES** Date of Diagnosis: Type 1 🞎 Type 2 🞎 Other 🞎 |
|  |  |
| **BLOOD GLUCOSE LEVELS**tARGET bLOOD gLUCOSE lEVEL: self-care blood glucose level checking skills:🞎 Independently checks own blood glucose🞎May check blood glucose with supervision🞎Requires assistance to check blood glucoseBGLs to be checked by whom: Self / Carer Frequency:  |
|  |
| **DIABETES SUPPORT (include reference to Duty Statement, Diabetes action Plan, Blood Glucose Chart, exercise regime, dietary supplement, etc):** |
|  |
| **DIABETES PRACTITIONERS:** |
| Name: | Address: |
| Role: | Email: |
| Phone: | Fax: |
|  |  |
| Name: | Address: |
| Role: | Email: |
| Phone: | Fax: |
|  |
| **Pharmacist** |  |
| Name: | Address: |
| Role: | Email: |
| Phone: | Fax: |
|  |

Participant / Nominee Signature:

Date:

**PARTICIPANT NAME**:

**PLAN DATE**:

# Staff acknowledgement

I have read and understood the Diabetes Management Plan for this participant.

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Worker Name** | **Worker Signature** | **Date** |
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