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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 glucose  BGLs 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.

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