

Take Charge of Your Diabetes Plus Participant Support Plan

Participant Number or Name: _____

Workshop ID: _____ **Site Name:** _____

Start date of program: _____ / _____ / _____ (e.g., 05/01/24)

Participant's POST-Program SMART goal: _____

RECOMMENDATIONS:

- | | |
|---|--|
| <input type="checkbox"/> Schedule Dentist appt _____ | <input type="checkbox"/> Pneumonia Vaccination _____ |
| <input type="checkbox"/> Schedule Foot Dr appt _____ | <input type="checkbox"/> A1C lab test _____ |
| <input type="checkbox"/> Schedule appt with Dietitian _____ | <input type="checkbox"/> HDL lab test _____ |
| <input type="checkbox"/> Schedule Eye Doctor appt _____ | <input type="checkbox"/> LDL lab test _____ |
| <input type="checkbox"/> Follow-up with Social Worker | <input type="checkbox"/> Cholesterol lab test _____ |
| <input type="checkbox"/> Join a Support Group | <input type="checkbox"/> Triglycerides lab test _____ |
| <input type="checkbox"/> Get Diabetes ID bracelet | <input type="checkbox"/> Microalbuminuria lab test _____ |
| <input type="checkbox"/> Quit Smoking | <input type="checkbox"/> Other: _____ |

RESOURCES:

Registered Dietician Signature: _____ **Date:** _____