

DSMES INTERVENTION TRACKING FORM 2

Participant Name: _____ Date of Birth: _____

Date of last DSMES Assessment: _____ Learning Needs: _____

DSMES PLAN

WHAT TOPICS: Healthy Coping Healthy Eating Being Active Taking Medication
 Monitoring Problem Solving Reducing Risks

HOW: Group Individual (special needs: _____)

WHERE: In-person Telehealth Telephone (audio-only) **WHEN** (date of first session): _____

DATE OF SERVICE:	START TIME:	END TIME:	GROUP OR INDIVIDUAL?	IN PERSON OR TELEHEALTH?
TOPICS COVERED Check all that apply	<input type="checkbox"/> Healthy Coping <input type="checkbox"/> Healthy Eating <input type="checkbox"/> Being Active <input type="checkbox"/> Taking Medication <input type="checkbox"/> Monitoring <input type="checkbox"/> Problem Solving <input type="checkbox"/> Reducing Risks <input type="checkbox"/> Other:			
Participant DSMES Progress and Plan:				
Clinical or Behavioral Outcome				
DSMES Team Signature:				

Participant's SMART goal: _____

Date goal set: _____ Date of goal follow up: _____ Goal Progress: Never Met 1 - 2 - 3 - 4 - 5 Always Met