DSMES SOAP Note Template (ADCES-Compliant)

Patient Name: [Insert Patient Name]
Date of Birth: [MM/DD/YYYY]
Date of Visit: [MM/DD/YYYY]
Provider: [Name], Credential
Visit Type: Initial/Follow-up DSMES Session
Diagnosis: Type 2 Diabetes Mellitus (ICD-10: E11.9)

S – Subjective

Chief Complaint:
[Patient's primary concern or reason for the visit]

History of Present Illness:
[Brief summary of the patient's diabetes history, recent blood glucose readings, A1c levels, and any symptoms or concerns]

Self-Monitoring:
[Frequency and timing of blood glucose checks]

Eating Habits:
[Description of eating patterns]

Physical Activity:
[Level and frequency of physical activity]

Medication Adherence:
[Current medications and barriers to taking, if relevant]

Psychosocial Factors:
[Living situation, emotional well-being, support systems]

Social Drivers of Health factors:

[Housing, food, affordability/access of healthcare, trust in medical providers, etc.)

O – Objective

Vital Signs:

BP: [Insert]

HR: [Insert]

Weight: [Insert]

Height: [Insert]

Relevant Laboratory Results:

Hemoglobin A1c: [Insert]

Fasting Blood Glucose: [Insert]

Physical Exam:
[Relevant findings]

A – Assessment

Type 2 diabetes mellitus with [describe control status, e.g., "suboptimal glycemic control (A1c 8.2%)"].

Contributing factors include [list relevant factors].

Patient demonstrates [level of engagement].

P – Plan

Education Provided:

[Topics covered, e.g., "Discussed the impact of carbohydrate intake on blood glucose levels."]

[Teaching methods, e.g., "Introduced the concept of the plate method for meal planning."]

[Materials provided, e.g., "Provided recommendation for blood glucose-tracking app."]

Behavioral Goals:

[Goal 1, e.g., "Patient will aim to incorporate at least one serving of non-starchy vegetables into each meal."]

[Goal 2, e.g., "Patient will set a goal to walk for 15 minutes daily, five days a week."]

Monitoring:

[Plan for self-monitoring, e.g., "Encouraged patient to check blood glucose levels twice daily (fasting and postprandial) and maintain a log."]

Follow-Up:

[Next steps, e.g., "Scheduled follow-up DSMES session in two weeks to assess progress and address any challenges."]

Referrals:

[Additional support, e.g., "Referred to a registered dietitian for personalized meal planning assistance."]

Additional Support:

[Community resources, e.g., "Provided information on local senior centers offering group exercise classes to address social isolation and promote physical activity."]

Signature:
[CDCES Name], CDCES
[Contact Information]