Glucose Record - Injections

E-mail to: BCESBloodSugar@bannerhealth.com

Patient Name:____________________ DOB:___/____/_____ Phone:______________ Long-acting insulin dose: ___ Time:____

Carb Ratios: Breakfast 1:____ Lunch 1:____ Dinner 1:____ Target: Day____ Night____ ISF (CF):____

Date:	**12:_**	**1:_**	**2:_**	**3:_**	**4:_**	**5:_**	**6:_**	**7:_**	**8:_**	**9:_**	**10:_**	**11:_**	**12:_**	**1:_**	**2:_**	**3:_**	**4:_**	**5:_**	**6:_**	**7:_**	**8:_**	**9:_**	**10:_**	**11:_**
Glucose																								
Carb Intake																								
Carb Dose																								
Correction Dose																								
Total Dose																								
Exercise																								
Urine Ketones																								

Date:	**12:_**	**1:_**	**2:_**	**3:_**	**4:_**	**5:_**	**6:_**	**7:_**	**8:_**	**9:_**	**10:_**	**11:_**	**12:_**	**1:_**	**2:_**	**3:_**	**4:_**	**5:_**	**6:_**	**7:_**	**8:_**	**9:_**	**10:_**	**11:_**
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***Exercise** (please indicate duration of activity i.e. 30 min)

***Ketones** = Ketones checked if BG >250 (please indicate result: N-negative, T-trace, S-small, M-moderate, L-large)

Banner Children's