

DATE: _____ NURSE: _____ NURSE: _____ NURSE: _____ NURSE: _____ PATIENT STICKER

GLYCEMIC CONTROL

TIME																		
FSBS mg/dL																		
Regular Insulin drip amt in units																		
Total Carbs eaten																		
Insulin bolus amt in units																		
Hypoglycemic Treatment																		
Multiplier																		
RN initials																		
RN initials																		

DATE: _____ NURSE: _____ NURSE: _____ NURSE: _____ NURSE: _____

GLYCEMIC CONTROL

TIME																		
FSBS mg/dL																		
Regular Insulin drip amt in units																		
Total Carbs eaten																		
Insulin bolus amt in units																		
Hypoglycemic Treatment																		
Multiplier																		
RN initials																		
RN initials																		