



VITAL SIGNS / DAILY BLOOD SUGAR AND INSULIN LOG

GLUCOMETER
MODEL TYPE: _____

PATIENT'S NAME: _____ MR: _____

Insulin Type: _____

Date	Time	BS Level mg/Dl	Insulin dose adm.	B/P	Pulse Temp.	Time	BS Level mg/Dl	Insulin dose adm.	B/P	Pulse Temp.	Time	BS Level mg/Dl	Insulin Dose adm.	B/P	Pulse Temp.	Nurse Initials
SUN																
MON																
TUE																
WED																
THU																
FRI																
SAT																

GLUCOSE METER QUALITY CONTROL LOG

DATE	CHECK STRIP TEST OK	TEST TRIP RANGE	CONTROL SOLUTION TEST RESULTS	CORRECTIVE ACTION IF APPLICABLE
	YES NO	NORMAL HIGH LOW	NORMAL HIGH LOW	

PLEASE MAKE SURE YOU CHECK EXPIRATION DATES FOR CONTROL SOLUTION (expires 90 days from date opened) and that vitals have been labeled when opened.

NURSE NAME: _____

NURSE SIGNATURE: _____

Experts Home Health

Daily Blood Sugar/Insulin log

TEAM COMMUNICATION

Patient Name: _____ MR#: _____

Model Type: _____ Serial #: _____

A.M.

P.M.

Date	BS Level	Insulin Dose Administered	Site	Nurse Initials	Date	BS Level	Insulin Dose Administered	Site	Nurse Initials	Team Communication
Sun										
Mon										
Tue										
Wed										
Thur										
Fri										
Sat										

GLUCOSE METER QUALITY CONTROL LOG

DATE	Check Strip Test OK		Test Strip Range			Control Solution Test Results			Corrective Action if applicable
	Yes	No	Normal	High	Low	Normal	High	Low	

PLEASE MAKE SURE YOU CHECK EXPIRATION DATES FOR CONTROL SOLUTIONS (expires 90 days from date opened) AND THAT VIALS HAVE BEEN LABELED WHEN OPENED.

* Nurse to send **ORIGINAL** to Agency along with nurse's notes on a weekly basis. Leave yellow copy inside folder at patient's home.

Nurse Signature: _____

Experts Home Health

Daily Blood Sugar/Insulin log

TEAM COMMUNICATION

Patient Name: _____ MR#: _____

Model Type: _____ Serial #: _____

A.M.					P.M.					Team Communication
Date	BS Level	Insulin Dose Administered	Site	Nurse Initials	Date	BS Level	Insulin Dose Administered	Site	Nurse Initials	
Sun										
Mon										
Tue										
Wed										
Thur										
Fri										
Sat										

GLUCOSE METER QUALITY CONTROL LOG

DATE	Check Strip Test OK		Test Strip Range			Control Solution Test Results			Corrective Action if applicable
	Yes	No	Normal	High	Low	Normal	High	Low	

PLEASE MAKE SURE YOU CHECK EXPIRATION DATES FOR CONTROL SOLUTIONS (expires 90 days from date opened) AND THAT VIALS HAVE BEEN LABELED WHEN OPENED.

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Nurse Signature: _____

Life Health Care, Inc.

WEEKLY BLOOD SUGAR LEVELS RESULTS

PATIENT: _____ MR#: _____

DATE: _____

DATES FROM: _____ - _____

VIA GLUCOMETER

RANGES	AM MG/DL	NOON MG/DL	PM MG/DL	HS MG/DL
SUN	FBS - RBS			
MON	FBS - RBS			
TUES	FBS - RBS			
WEDS	FBS - RBS			
THURS	FBS - RBS			
FRI	FBS - RBS			
SAT	FBS - RBS			

___ STABLE and WITHIN DESIRED LIMITS

___ ABOVE NORMAL, REQUES CHANGE TO TREATMENT REGIMEN

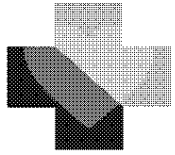
___ BELOW NORMAL, MD AWARE-NO CHANGE REQUEST TO TREATMENT REGIMEN

___ ABOVE NORMAL, REQUEST CHANGE IN TREATMENT REGIMEN

___ BELOW NORMAL, MD AWARE-NO CHANGE IN TREATMENT REGIMEN

MD: _____

FAX #: _____



Preferred Care

HOME HEALTH SERVICES

DAILY BLOOD SUGAR
GRAPHIC SHEET

PATIENT NAME: _____

MR: _____

		SUN	MON	TUES	WED	THUR	FRI
DATE		/ /	/ /	/ /	/ /	/ /	/ /
AM	BS LEVEL (MG/DL)						
	INSULIN DOSE ADMINISTERED						
	SITE						
	NURSE INITIAL						
NOON	BS LEVEL (MG/DL)						
	INSULIN DOSE ADMINISTERED						
	SITE						
	NURSE INITIAL						
PM	BS LEVEL (MG/DL)						
	INSULIN DOSE ADMINISTERED						
	SITE						
	NURSE INITIAL						
HS	BS LEVEL (MG/DL)						
	INSULIN DOSE ADMINISTERED						
	SITE						
	NURSE INITIAL						

BOTTLE EXP. DATE: ___/___/___	DATE OPENED: ___/___/___	TEST STRIP RANGE: _____ CIRCLE ONE: NORMAL - HIGH - LOW
CONTROL SOLUTION EXP. DATE: ___/___/___	DATE OPENED: ___/___/___	CONTROL SOLUTION RESULT: _____ CIRCLE ONE: NORMAL - HIGH - LOW

REPEAT CONTROL SOLUTION TEST WEEKLY AND WHEN:

- BATTERY IS CHANGED
- METER FALLS DOWN

* NOTIFY MD AND CASE MANAGER **IF** BLOOD SUGAR LEVEL IS LESS THAN 60 OR GREATER THAN 400

COMMENTS: _____



Patient Name: _____ MR#: _____
 Model Type: _____ Serial #: _____

Date	Time	BS Level	Insulin Dose	Nurse Initial	Comments
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	PM				
	HS				

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SAMPLE

GLUCOSE METER QUALITY CONTROL LOG

DATE	Check Strip Test OK		Test Strip Range			Control Solution Test Results			Corrective Action if applicable
	Yes	No	Normal	High	Low	Normal	High	Low	

PLEASE MAKE SURE YOU CHECK EXPIRATION DATES FOR CONTROL SOLUTIONS (expires 90 days from date opened) AND THAT VIALS HAVE BEEN LABELED WHEN OPENED. * Nurse to send **ORIGINAL** to Agency along with nurse's notes on a weekly basis. Leave yellow copy inside folder at patient's home.

Nurse Signature: _____

Signature: _____

BLOOD SUGAR/ VITAL SIGNS/ DAILY GLUCOSE METER QUALITY CONTROL



CLIENT'S NAME: _____ MR# _____ WEEK DATE FROM: _____ TO: _____

INSULIN ORDER AT AM: _____ INSULIN ORDER AT PM: _____

AM							PM										
DATE	BS/mg/dl	UNITS/SQ	CALIB	B/P	R	T	P	INITIALS	DATE	BS/mg/dl	UNITS/SQ	CALIB	B/P	R	T	P	INITIALS
SUN									SUN								
MON									MON								
TUE									TUE								
WED									WED								
THU									THU								
FRI									FRI								
SAT									SAT								

GLUCOSE METER QUALITY CONTROL LOG (perform daily)

CALIBRATION NORMAL RANGE _____

Perform quality control checks of glucose monitors:

- * The first time meter is used.
- * Routinely, once daily.
- * Each time a new vial of test strip is opened.
- * If the meter has been dropped or if there has been trauma to the meter.
- * After the battery has been replaced.
- * As per manufacturer's guidelines if more stringent.

Test Strip Range		
Low	High	Normal

SLIDING SCALE

to _____ = _____ Units to _____ = _____ Units
 to _____ = _____ Units to _____ = _____ Units
 to _____ = _____ Units to _____ = _____ Units
 More than _____ mg/dl administer insulin and call MD

CORRECTIVE ACTION IF APPLICABLE

Nurse Name: _____ Nurse Signature: _____ RN/ LPN
 Nurse to send ORIGINAL to Agency along with nurses note on a weekly basis. Leave yellow copy inside Patient's Home folder.