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: _____

HUMAN TOUCH HOME HEALTH, INC.

DAILY BLOOD SUGAR / INSULINE LOG

Patient Name:_____MR#:_____

Model Type: _____ Serial #: _____

A.M. Noon

DATE	TIME	BS LEVE	Insulin Dose	SIDE	Nurse Initials	DATE	TIME	BS LEVEL	Insulin Dose Administered	SIDE	Nurse Initials
SUN. / /						SUN. / /					
MON. / /						MON. / /					
TUE. / /						TUE. / /					
WED. / /						WED. / /					
THUR. / /						THUR. / /					
FRI. / /						FRI. / /					
SAT. / /						SAT. / /					

P.M. B.T.

DATE	TIME	BS LEVEL	Insulin Dose Administered	SIDE	Nurse Initials	DATE	TIME	BS LEVEL	Insulin Dose Administered	SIDE	Nurse Initials
SUN. / /						SUN. / /					
MON. / /						MON. / /					
TUE. / /						TUE. / /					
WED. / /						WED. / /					
THUR.. / /						THUR. / /					
FRI. / /						FRI. / /					
SAT. / /						SAT. / /					

GLUCOSE METER QUALITY CONTROL LOG

Date	Check Strip Test OK		TEST STRIP RANGE			CONTROL SOLUTION TEST RESULT			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 NAME:_____ NURSE SIGNATURE: _____

EMAL PROFESSIONAL SERVICE

Daily Blood Sugar/Insulin log

TEAM COMMUNICATION

Patient Name: _____ MR#: _____

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										
Thu										
Fri										
Sat										
NIGHT										
Sun										
Mon										
Tue										
Wed										
Thu										
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: _____

GET WELL SOON
HOME HEALTH SERVICES

VITAL SIGNS / DAILY BLOOD SUGAR AND INSULIN LOG

PATIENT'S NAME: _____ MR: _____ GLUCOMETER MODEL TYPE: _____

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:** _____

TEAM COMMUNICATION
DAILY LOG

Patient Name: _____ MR#: _____

Date	AM	BS Level	Insulin/Dose Site	BP P	Temp R	PM	BS Level	Insulin/Dose Site	BP P	Temp R	Nurse Initials
Sun											
Mon											
Tues											
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: _____

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 #:** _____

Solution Home Health Care, Inc.

PATIENT: ____

DAY	TIME	TEMP	BS	RESP.	PULSE	BP	INJECTION SITE

SUPERIOR
Home Health Group, Corp.

5787-A NW 151 St.
Miami Lakes, Fl 33014
Ph: 305-362-5464
Fax: 305-362-5465
Email: superiorhhg@bellsouth.net

Date: _____

Week of: _____

Through: _____

WEEKLY BLOOD SUGAR / INSULIN LOG

Patient's Name: _____ MR#: _____

Date/Time	Temp	Pulse	Resp.	B/P	BSL	Insulin / Site	Initials

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.

Signature: _____ RN/LPN Date End: _____

Alliance Home Health, Inc.

DAILY BLOOD SUGAR AND INSULIN LOG

PATIENT'S NAME: _____ **MR:** _____ **MODEL TYPE:** _____

Date	Time	BS Level mg/Dl	Insulin Dose adm.	B/P	Date	Time	BS Level mg/Dl	Insulin Dose adm.	B/P	Date	Time	BS Level mg/Dl	Insulin dose adm.	B/P	Nurse Initials

GLUCOSE METER QUALITY CONTROL LOG (ONCE WEEKLY)

DATE	TEST STRIPS LOT No. _____ EXPIRATION DATE: _____	BOTTLE FIRST OPEN DATE: _____ DISCARD AFTER 6 MONTHS	TEST STRIPS RANGE: _____ HIGH NORMAL LOW	REPEAT CONTROL SOL. TEST IF: - RESULT IS ABNORMAL AND PT IS OK. - IF BATTERY IS CHANGED - IF METER FALLS DOWN - WHEN NEW BOTTLE OF STRIPS IS FIRST OPEN
	CONTROL SOL. LOT No. _____ CONTROL SOL. EXP. DATE: _____	BOTTLE FIRST OPEN DATE: _____ DISCARD AFTER 6 MONTHS	CONTROL SOL. TEST RESULT: _____ NORMAL HIGH LOW	CORRECTIVE ACTION IF APPLICABLE:

NURSE NAME AND SIGNATURE: _____

Preferred Care
HOME HEALTH SERVICES

DAILY BLOOD SU
GRAPHIC SHE

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:

1. BATTERY IS CHANGED
2. METER FALLS DOWN

* NOTIFY MD AND CASE MANAGER ***IF*** BL
LEVEL IS LESS THAN 60 OR GREATER TH

COMMENTS:_____

MD Nursing, Corp.

Diabetic Monitoring Log

Date	Time	Blood Sugar Results MG/DL	What may affect test results? (e.g. Missed meals, or Snacks)	Type of Insulin given	# of Units	Where given (see injection Codes Below)	Employees' Initials

1) Right Anterior Thigh
2) Left Anterior Thigh
3) Right Arm
4) Left Arm
5) Right Abdominal Area
6) Left Abdominal Area
7) Other: _____

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.

MR#: _____

Nurse's Signature: _____ Patient Name: _____

Daily Blood Sugar/Insulin Log

Team Communication

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				

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:** ______________________

HOME HEALTH NURSING SERVICES, INC.

Weekly Blood Sugar Monitoring Log

Patient Name: _____ MR #: _____

MD Name: _____ MD Fax: _____

Date	Time	Glucose Level	Insulin Given and Site	Comments

GLUCOSE METER QUALITY CONTROL LOG

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

Discard Control Solution after 90 Days of Opening.

Quality Control test must be done:
* When new test strip botle is opened
* If meter fails
* If Pt's condition contradicts results
* At lest weekly

Nurse Signature: _____

Happy Heart Home Health Care, Inc

BLOOD SUGAR/ VITAL SIGNS/ DAILY GLUCOSE METER QUALITY CONTROL

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

INSULIN ORDER AT AM:

AM

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

INSULIN ORDER AT PM:

PM

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

GLUCOSE METER QUALITY CONTROL LOG (perform daily)

CALIBRATION NORMAL RANGE _____

Test Strip Range		
Low	High	Normal

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 oppened.
* If the meter has been dropped or if there has been trauma to the meter.
* After the battery has been replaced.
* As per manufacture's guidelines if more stringent.

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 nurse's note on a weekly basis. Leave yellow copy inside Patien's Home folder.

Total Home Health Care, Inc.

Weekly MD Reports for Blood Sugar/Blood Pressure Log

NURSE NAME: _____

PATIENT NAME: _____

DATE: _____ FROM _____ TO _____

* Any patient status **Must** be documented on the back of this form.

MR#: _____

Date Faxed To MD: _____

Date	Write the Time	BP	Pulse A	Pulse R	RESP	TEMP	BS LEVEL	INSULIN TYPE	INSULIN DOSE	SITE ADMINISTERED	MEDICINE TAKEN ORALLY (Y / N)	PAIN LEVEL/LOCATION/ ACTION
SUN	AM:											
	NOON:											
	PM:											
MON	AM:											
	NOON:											
	PM:											
TUE	AM:											
	NOON:											
	PM:											
WED	AM:											
	NOON:											
	PM:											
THUR	AM:											
	NOON:											
	PM:											
FRI	AM:											
	NOON:											
	PM:											
SAT	AM:											
	NOON:											
	PM:											