Experts Home Health

Daily Blood Sugar/Insulin log

TEAM COMMUNICATION

Patient	: Nam	e:											MR#:	
Model [*]	Туре:											Seri	ial #:	
A.M.						P.M.								
Date	BS Level		n Dose nistered		Nurse Initials	Date	BS Level	Insulin Admin	Dose distered	Site	Nurse Initials	Team Comm	nunication	
Sun														
Mon														
Tue											2	>		
Wed									2					
Thur								S	<u>\(\) \(\)</u>	(/				
Fri														
Sat					N		6							
	•	•		7	GLUC	OSE N	IETER	QUALI	TY CO	NTRO	L LOG	•		
	000,000,000,000,000	Check Sfri	p Test OK		Test	t Strip R	ange		Contr	ol Solu	tion Tes	r Results		
DAT	E	Yes	No	Norr	mal	High	L	ow	Norma	al .	High	Low	Corrective Action i applicable	
			YOU CH					OR CON	ITROL S	SOLUT	IONS (e	xpires 90	days from date opened) A	
* Nurse t	o send	ORIGIN	AL to Ag	ency alc	ong with	nurse's	notes on	a weekly	y basis. I	eave ye	ellow cop	y inside f	folder at patient's home.	
Nurse S	ignatu	ıre:												



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 Admin		SIDE	Nurse Initials
SUN.		BETT				SUN.						
MON.						MON.						
TUE.						TUE.		0				
WED.						WED.	-0					
THUR.						THUR.	C					
FRI.						FRI.						
SAT.						SAT.	<i>(</i>).					
P.M.		_				B.T.			1			
DATE	TIME	BS LEVE	Insulin I L Administe		Nurse Initials	DATE	TIME	BS LEVEL	Insulin Admin		SIDE	Nurse Initials
SUN.				(SUN.						
MON.				W.	C	MON.						
TUE.				0		TUE.						
WED.			24			WED.						
THUR						THUR.						
FRI.			P			FRI.						
SAT.						SAT.						
				I				1			1	1
D /	Check	Ctuin	GLUCO	SE ME	TER Q	UALITY	CONI	rol i	LOG	T		
Date		t OK	TEST ST	TRIP RANG	Е	CONTROL	SOLUTIO	N TEST R	ESULT		CTIVE ACTI APPLICABLI	
	YES	NO	NORMAL	HIGH	LOW	NORMAL	HIGI	H	LOW			
			CHECK EXPI EEN LABELEI			CONTROL S	OLUTION	S (EXPIRE	S 90 DA	YS FRO	M DATE C	PENED)

• 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: _____



Patient Name: ______ MR#: _____

Daily Blood Sugar/Insulin log

Nurse Signature:

TEAM COMMUNICATION

A.IVI.						P.IVI.						
Date	BS Level	Insulin Do		Site	Nurse Initials	Date	BS Level	Insulin Dose Administered	Site	Nurse Initials	Team Communi	cation
Sun												
Mon												
Tue												
Wed)			
Thu									C)		
Fri								2	*			
Sat								XO,				
				_			Ń	NICHT	\mathbf{Y}			
Sun							S					
Mon						Ó		M				
Tue					.3		S					
Wed					12)					
Thu				7								
Fri												
Sat												
					GLUC	OSE N	ETER	QUALITY CO	NTRO	L LOG		
DAT		heck Strip Te	est OK		Test	Strip R	ange	Conti	ol Solu	tion Test F	Results	Corrective Action if
DAI		Yes	No	Nor	mal	High	L	ow Norma	al H	ligh	Low	applicable
PLEASE THAT V	MAKE	SURE YO	U CHE LABE	ECK E	XPIRAT WHEN C	ION DA	TES FC).	R CONTROL S	SOLUTI	IONS (exp	oires 90 da	ays from date opened) AND
* Nurse t	o send C	RIGINAL	to Age	ency al	ong with	nurse's	notes on	a weekly basis. I	_eave ye	llow copy	inside fold	er at patient's home.



VITAL SIGNS / DAILY BLOOD SUGAR AND INSULIN LOG

PATIEN Insulin T		le:		***************************************		***********************************			GLUCOMETER MR: MODEL TYPE:					***************************************		
Date	Time	BS Level mg/DI	Insulin dose adm.	В/Р	Pulse Temp.	Time	BS Level mg/DI	Insulin dose adm.	B/P	Pulse Temp.	Time	BS Level mg/DI	Insulin Dose adm.	В/Р	Pulse Temp.	Nurse Initials
SUN																
MON									V.							
TUE								X (S)								
WED							5	N								
THU							S									
FRI					XXX)									
SAT																
					GLL	JCOSE	METER	QUALITY	CONT	ROL LOG)					
DA	ATE		HECK STRI TEST OK			TEST T		,		L SOLUTION	N	CORRI	ECTIVE AC	TION IF	APPLIC	ABLE
		Y	ES N	0	NORM	IAL HI	GH LO	w No	RMAL	HIGH	LOW					
PLEASE	MAKE SU	RE YOU C	HECK EXPI	RATION	DATES FO	OR CONT	ROL SOL	UTION (exp	oires 90 da	ys from date	opened) a	nd that vital	s have been	labeled \	when open	ed.

NURSE SIGNATURE:

NURSE NAME: _____



TEAM COMMUNICATION DAILY LOG

Patient	Name: ₋							M	R#:		
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							c				
Tues						en	\·\				
Wed						NP)					
Thur											
Fri			1								
Sat											

GLUCOSE METER QUALITY CONTROL LOG

	Check Strip Test OK		Test Strip Range			Control S	olution Tes		
DATE	Yes	No	Normal	High	Low	Normal	High	Low	Corrective Action if applicable

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 Signature:	

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



WEEKLY BLOOD SUGAR LEVELS RESULTS

PATIENT:			MR#:	
DATE:				
DATES FROM:				
VIA GLUCOMETEI	R			
RANGES	AM MG/DL	NOON MG/DL	PM MG/DL	HS MG/DL
SUN	FBS - RBS			
MON	FBS - RBS		0.	
TUES	FBS - RBS	*ell		
WEDS	FBS - RBS	30		
THURS	FBS - RBS	0. 11		
FRI	FBS - RBS	S		
SAT	FBS - RBS			
STABLE and V	VITHIN DESIRED L	IMITS		
ABOVE NORM	MAL, REQUES CHA	NGE TO TREATME	ENT REGIMEN	
BELOW NOR	MAL, MD AWARE-1	NO CHANGE REQU	EST TO TREATME	NT REGIMEN
ABOVE NORM	MAL, REQUEST CH	ANGE IN TREATM	ENT REGIMEN	
BELOW NORM	MAL, MD AWARE-1	NO CHANGE IN TR	EATMENT REGIMI	EN
MD:			FAX #:	

Solution Home Health Care, Inc.

PATIENT:		

DAY	TIME	TEMP	BS	RESP.	PULSE	ВР	INJECTION SITE
					-0		
				(2)			
			6				
			0, ~	10.			
		<i>h</i>					
			5				
		199					
		10					



Temp

Date/Time

Patient's Name:

Resp.

Pulse

5787-A NW 151 St. Miami Lakes, Fl 33014

Ph: 305-362-5464 Fax: 305-362-5465

B/P

Week of:	
Through:	

MR#: _____

Insulin / Site

Date End:

Date:

Initials

Email: superiorhhg@bellsouth.net

WEEKLY BLOOD SUGAR / INSULIN LOG

BSL

DATE	Yes	No	Normal	High	Low	Normal	High	Low	_ applica	ble
	Check Stri	p Test OK		st Strip Ran				st Results	Corrective /	
			GLUCC	SE METEI	│ R QUALIT	Y CONTR	OL LOG			
			1/2							
			10		D '					
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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

DAILY BLOOD SUGAR AND INSULIN LOG

PAI	IEN I 'S N	IAIVIE:							WR:		IV	IODEL IN	rpe:		
Date	Time	BS Level mg/DI	Insulin Dose adm.	B/P	Date	Time	BS Level mg/DI	Insulin Dose adm.	B/P	Date	Time	BS Level mg/Dl	Insulin dose adm.	B/P	Nurse Initials
									C						
								-(1	*						
								KO,	4						
							7/2	2							
						4	(2)	N							
						, 0		11.							
					2.5	11.	C								
		1		1				•	1	1		1			

GLUCOSE METER QUALITY CONTROL LOG (ONCE WEEKLY)

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

NURSE NAME AND SIGNATURE:	HONGE HAME AND CICHATONE.
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PAT	IENT NAME:										I	MR:	
		SU	JN	M	ON	TUI	ES	W	/ED	ТН	UR	FI	રા
	DATE	1	1	1	1	1	1	1	1	1	I	1	1
	BS LEVEL (MG/DL)												
AM	INSULIN DOSE ADMINISTERED												
7	SITE												
	NURSE INITIAL								6				
	BS LEVEL (MG/DL)							3	. *				
NOON	INSULIN DOSE ADMINISTERED						×C		(,				
ž	SITE						7	a					
	NURSE INITIAL				- (5		X					
	BS LEVEL (MG/DL)				6	7							
P.M.	INSULIN DOSE ADMINISTERED			N		5							
	SITE		1										
	NURSE INITIAL												
	BS LEVEL (MG/DL)												
오	INSULIN DOSE ADMINISTERED												
	SITE												
	NURSE INITIAL												
BOTTLE EXP. DATE:					DATE O	PENED	-	TEST STRIP RANGE:CIRCLE ONE: NORMAL - HIGH - LOW)WC	
CC	NTROL SOLUTION //		ATE:	[,	PENED	: :	CONTROL SOLUTION RESULT:CIRCLE ONE: NORMAL - HIGH - LOW					
	EAT CONTROL SO	LUTION	TEST	WEEKI	LY AND	WHEN:			IFY MD L IS LES				
	METER FALLS DOW							COMN	MENTS:				

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
				5			
			c				
			N C) ·			
			7				
			7				

 Right Anterior Thigh 	1)	Rig	ht /	٩nt	erior	Τh	ıigl	h
--	---	---	-----	------	-----	-------	----	------	---

2) Left Anterior Thigh

3) Right Arm

4) Left Arm

- 5) Right Abdominal Area
- 6) Left Abdominal Area

MR#: _____

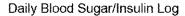
7) Other: _____

GLUCOSE METER QUALITY CONTROL LOG

DATE	Check Str OF		Te	st Strip Ran	ge	Control S	olution Te	st Results	Corrective Action if
	Yes	No	Normal	High	Low	Normal	High	Low	applicable

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's Signature:	Patient Name: _	



_	_		
Team	Commi	inicatio	۱ı



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

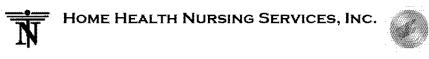
Date	Time	BS Level	Insulin Dose	Nurse Initial	Comments
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	РМ				
	HS				
	AM				
	Noon				
	РМ			² O,	
	HS			9	
	AM				
	Noon		×0,	/ .	
	PM		(5)		
	HS		(N /N)		
	AM		V3 ///		
	Noon	•	0, 7/4.		
	PM	la.			
	HS		9		
	AM				
	Noon				
	PM				
	HS				
	AM				
	Noon				
	PM				
	HS				

GLUCOSE METER QUALITY CONTROL LOG

Check Strip Test OK	Test Strip Ran	ge Control S	Solution Test Results	
Yes No	Normal High	Low Normal	High Low	Corrective Action if applicable

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:



Weekly Blood Sugar Monitoring Log

Patient Na	me:			MR #:			
				MD Fax:			
Date	Time	Glucose Level	Insulin Given and Site	Comments			
			c _O ,				
			~°°° (),				
		N.	·				
		IN.					

GLUCOSE METER QUALITY CONTROL LOG

Normal Test Strip Range

Discard Control Solution after 90 Days of Opening.

No

Check Strip Test OK

Yes

DATE

Quality Control test must be done:

Corrective Action (if applicable)

- * When new test strip botle is opened
- * If meter fails

Control Solution Test Results

- * If Pt's condition contradicts results
- * At lest weekly

Nurse Signature:	
-	





CLIENT'S NAME:_____ WEEK DATE FROM: ______ TO:____ INSULIN ORDER AT PM: INSULIN ORDER AT AM: AM BS/mg/dl UNITS/SQ UNITS/SQ CALIB. P INITIALS CALIB DATE BS/mg/dl B/P DATE B/P INITIALS SUN SUN MON MON TUE TUE WED WED THU THU **ERI** FRI SAT GLUCOSE METER QUALITY CONTROL LOG (perform daily) SLIDING SCALE CALIBRATION NORMAL RANGE Test Strip Range Units Units Low | High | Normal Perform quality control checks of glucose monitors: Units Units * The first time meter is used. Units * Routinely, once daily. More than __ _mg/dl administer insulin and call MD * 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. CORRECTIVE ACTION IF APPLICABLE * As per manufacture's guidelines if more stringent.

Nurse Name: _____ 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.



Weekly MD Reports for Blood Sugar/Blood Pressure Log

NURSE NAME:			* Any patient status <u>Must</u> be documented on the back of this form.			
PATIENT NAME:			MR#:			
DATE:	_ FROM	_TO	Date Faxed To MD:			

Date	Write the Time	BP	Pu A	ulse R	RESP	ТЕМР	BS LEVEL	INSULIN TYPE	INSULIN DOSE	SITE ADMINISTERED	MEDICINE TAKEN ORALLY (Y / N)	PAIN LEVEL/LOCATION/ ACTION
	AM:											
SUN	NOON:											
	PM:											
	AM:											
MON	NOON:									/ .		
	PM:							11.				
	AM:							5				
TUE	NOON:							11 1				
	PM:							2 0				
	AM:						12	S				
WED	NOON:						7					
	PM:					N						
	AM:											
THUR	NOON:											
	PM:											
	AM:											
FRI	NOON:											
	PM:											
	AM:											
SAT	NOON:											
	PM:											