WHAT MEDICATION IS THE PATIENT TAKING

PLEASE PRINT CLEARLY

Patient Name	Date

DRUG ALLERGIES

INSULIN REGIMEN			INSULIN PUMP REGIMEN		
Insulin Name	Units	When? (morning, evening, meals)	Insulin		
		AM	Time Schedule	Basal Rate	Mealtime
		PM			Units to
		Breakfast			Gm of Carbs
		Lunch			
		Dinner			
		Bedtime			
If you use a sliding scale, what is your formula?					
Sliding scale for Blood Sugar greater than					
Blood sugar minus 100 divided by					

MEDICATION NAME For insulin please specify pens or vials Also include glucose test strips, insulin syringes and/or pen needles	DOSAGE (MG, UNITS, ETC	HOW DO YOU TAKE THIS MEDICATION? (example 1 a day, 1 twice a day)	PRESCRIBING DOCTOR