MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE

LOCAL FORM TITLE

INSULIN INFUSION PROTOCOL FLOWSHEET

DEMOGRAPHICS

Gender: ☐ Male ☐ Female Age:_____ Weight:_____kg Height:_____inches BMI:_____

History of Diabletes: ☐ Yes ☐ No

If Yes, ☐ Home Insulin Required_____ ☐ Diet Controlled_____ ☐ Oral Agent_____

Medications:

IV/Oral Corticosteroids: ☐ Yes ☐ No

Epinephrine/Norepinephrine: ☐ Yes ☐ No

Betablockers: ☐ Yes ☐ No

Any issues/concerns during use of protocol:_____

Date:_____ Time	Bedside Glucose	Insulin Infusion Rate	Symptoms of Hypoglycemia*	Type of Treatment for Hypoglycemia	Diet
0700					
0800					
0900					
1000					
1100					
1200					
1300					
1400					
1500					
1600					
1700					
1800					
1900					
2000					
2100					
2200					
2300					
0000					
0100					
0200					
0300					
0400					
0500					
0600					

*Symptoms of hypoglycemia include shaking, sweating, hunger, weakness, anxiousness, confusion, slurred speech, lack of coordination or bedside glucose less than 60 mg/dL without symptoms

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	