BLOOD GLUCOSE TRACKING SHEET

Phone: (801) 213-3599 ♦ Fax: (801) 587-7539
pcmcbglogs@imail.org

Patient name:_____ Date of birth:_____ Date of diagnosis:_____

Contact name:_____ Phone:_____ Alternate phone: _____

☐ Lantus ☐ Levemir ☐ Basaglar ☐ Tresiba (degludec) ☐ Toujeo **Dose**: _____units **Time of day**: _____
☐ Novolog ☐ Humalog ☐ Apidra

Carbohydrate/Insulin ratio:_____ unit(s) per _____ grams of carb
Correction dose: _____ unit(s) insulin for every _____ blood glucose points above: _____ day _____ night

Healthcare Provider

☐ Murray ☐ Foster ☐ Hamaker ☐ Raman ☐ Clements ☐ Brown ☐ Galbraith
☐ Smego ☐ Lindsay ☐ Al-Hamad ☐ Ang ☐ Raleigh ☐ Wellisch

Blood Glucose Levels										Insulin Dosage						
										Morning		Lunch		Dinner		
Day	Date	Brkfst	Lunch	Snack	Dinner	Bed	Other	Other	Other	Insulin	Carb	Insulin	Carb	Insulin	Carb	Bed
Mon																
Tue																
Wed																
Thu																
Fri																
Sat																
Sun																

Blood Glucose Levels										Insulin Dosage						
										Morning		Lunch		Dinner		
Day	Date	Brkfst	Lunch	Snack	Dinner	Bed	Other	Other	Other	Insulin	Carb	Insulin	Carb	Insulin	Carb	Bed
Mon																
Tue																
Wed																
Thu																
Fri																
Sat																
Sun																

Parent/Guardian concerns about the reported blood glucose levels:_____

_____

Clinic recommendations:_____

_____

_____

Provider signature:_____ Date:_____ Time:_____

Dbt Nt 50288

Intermountain® Primary Children's Hospital