

Patient Name/Addressograph

Diabetes Discharge Prescription

Allergies:						QTY	REF
Insulin:							
"Basal Insulin" (specify insulin type)-----sig----- "Mealtime Insulin"(specify insulin type)----- ----- sig: Inject sub Q three times daily before each meal -----units PLUS Correction Scale selected below.						1 Vial	
Physician to designate insulin Correction Dose :							
Correction Scale: Specify insulin type							
	MILD Insulin Sensitive Lean/Elderly/Renal	MODERATE Average weight	AGGRESSIVE Insulin Resistant Infection/ Obese/ Steroids	CUSTOM	BG mg/dL	----- Vial	
151-200	1 Units	2 Units	4 Units	Units	151-200		
201-250	2 Units	3 Units	5 Units	Units	201-250		
251-300	3 Units	5 Units	7 Units	Units	251-300		
301-350	4 Units	6 Units	8 Units	Units	301-350		
351-400	5 Units	7 Units	10 Units	Units	351-400		
>400	Call MD	Call MD	Call MD	Call MD	>400		
Basal Insulin (Specify type) ----- sig:						-----vial	
Short acting/ Rapid acting Insulin (Specify type)-----sig:						-----vial	
Oral Diabetes Medication:							
-----mg sig:-----							
-----mg sig:-----							
-----mg sig:-----							
-----mg sig:-----							
-----mg sig:-----							
-----mg sig:-----							
OTHER:							
Insulin Syringes: (specify type)-----						Box of -----	
Alcohol Wipes						Box of -----	
Glucose Tablets						----- size	
Glucose get 15						-----tube	
----- Test Strips or generic(Testing----- times daily)						-----	
Lancets (Testing ----- times daily)						-----	
This prescription NOT VALID for Controlled Substances							
_____ Physician Printed Name Signature				_____ Date			
_____ Address				_____ Telephone			
_____				_____ License			
_____				_____ DEA Number			