



PATIENT NAME:	DATE OF BIRTH:	NEXT APPOINTMENT DATE & TIME:
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CURRENT BLOOD SUGAR MEDICATIONS: please include dosage and how many times a day you take the medication, if any.

Metformin: _____ Humulin/Novolin N: _____

Novolog/Humalog: _____

TARGET BLOOD SUGAR LEVELS
FASTING: no higher than **95**
1 HOUR AFTER EATING: no higher than **140**
2 HOURS AFTER EATING: no higher than **120**

DATE	FASTING	1 or 2 Hours AFTER			If your blood sugar is out of range, please list what you ate/drank for that meal
		BREAKFAST	LUNCH	DINNER	
		(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	
		(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	
		(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	
		(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	
		(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	
		(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	
		(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	(Check Either) <input type="checkbox"/> 1HR <input type="checkbox"/> 2HRS _____	

If your MAIN office for appointments is (check one):	Please email your glucose logs WEEKLY to:
<input type="checkbox"/> North Austin (Renfert Way)	AMFM.Nurse@hcahealthcare.com
<input type="checkbox"/> Cedar Park	AMFM.Nurse.CP@hcahealthcare.com
<input type="checkbox"/> South Austin (James Casey South)	NAMC.JCaseyfax@hcahealthcare.com
<input type="checkbox"/> Downtown Austin (IH35)	DowntownRN@hcahealthcare.com
<input type="checkbox"/> Harker Heights	HHNurse@hcahealthcare.com
<input type="checkbox"/> Brownwood <input type="checkbox"/> College Station <input type="checkbox"/> Columbus <input type="checkbox"/> Fredericksburg <input type="checkbox"/> Georgetown	AMFMTelemedRN@hcahealthcare.com
<input type="checkbox"/> Gonzales <input type="checkbox"/> LaGrange <input type="checkbox"/> Marble Falls <input type="checkbox"/> San Angelo <input type="checkbox"/> San Marcos	

Please check your main provider:

Dr. Adusumalli Dr. Bednar Dr. DeStefano Dr. Haeri Dr. Herrera
 Dr. Hill Dr. Holliman Dr. McDonnold Dr. Monsivais Dr. Nielsen Dr. Singh