



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 _____	

<b>If your MAIN office for appointments is (check one):</b>	<b>Please email your glucose logs WEEKLY to:</b>
<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.JCaseyefax@hcahealthcare.com
<input type="checkbox"/> Downtown Austin (IH35)	DowntownRN@hcahealthcare.com
<input type="checkbox"/> Harker Heights	HHNurse@hcahealthcare.com
<input type="checkbox"/> College Station	AMFM.Nurse.CollegeStation@hcahealthcare.com
<input type="checkbox"/> Brownwood <input type="checkbox"/> Columbus <input type="checkbox"/> Fredericksburg <input type="checkbox"/> Georgetown <input type="checkbox"/> Gonzales	AMFMTelemedRN@hcahealthcare.com
<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. Hadley  Dr. Haeri  Dr. Herrera

Dr. Hill  Dr. Holliman  Dr. McDonnold  Dr. Monsivais  Dr. Nielsen  Dr. Singh