Children's Medical Center of Dallas 1935 Motor Street Dallas, Texas 75235 (214) 456-7000 **ENDOCRINOLOGY CENTER** **Intensive Management** **Blood Glucose Log**	Med Rec No. _______________ Acct. No. _______________. Patient:____. LABEL Date: ____________________ Location:_______________. DOB: _______________.

Please mail to address listed above or send form via Fax to: (214) 456-5963

Phone H: (_____)______-_________ **W:** (_____) ______- _________ Secure**Fax** (_____)______-__________

Date:

	3 AM	Pre-Bkfst	Post-Bkfst	Pre-Lunch	Post-Lunch	Pre-Dinner	Post-Dinner	Bedtime	Mid-Night
Time									
BG									
Carbs									
Meal Bolus + Corr Bolus									
Comments:									

Date:

	3 AM	Pre-Bkfst	Post-Bkfst	Pre-Lunch	Post-Lunch	Pre-Dinner	Post-Dinner	Bedtime	Mid-Night
Time									
BG									
Carbs									
Meal Bolus + Corr Bolus									
Comments:									

Date:

	3 AM	Pre-Bkfst	Post-Bkfst	Pre-Lunch	Post-Lunch	Pre-Dinner	Post-Dinner	Bedtime	Mid-Night
Time									
BG									
Carbs									
Meal Bolus + Corr Bolus									
Comments:									

Endocrine Office Use Only

Treatment Interventions:

Physician Signature ______________________ Date_________
Staff Signature ___________________________ Date_________