Children's Medical Center of Dallas
1935 Motor Street Dallas, Texas 75235 (214) 456-7000
ENDOCRINOLOGY CENTER
Blood Glucose Log

Med Rec No. _____ Acct. No. _____.
Patient:_____.
LABEL
Date: _____ Location:_____.
DOB: _____.

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

Phone H: (____)_____-_____ **W:** (____) _____- _____ **Secure Fax** (_____)_____-_____

Day of	Breakfast		Lunch		Dinner		Bedtime		
Month	Blood Gluc	Insulin /Dose	Blood Gluc	Insulin /Dose	Blood Gluc	Insulin /Dose	Blood Gluc	Insulin /Dose	Patient/Parent Comments
1									
2									
3									
4									
5									
6									
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27									
28									
29									
30									
31									

Endocrine Office Use Only

Treatment Interventions:

Physician Signature _____ Date
Staff Signature _____ Date_____

Glucose Log standard 02/22/05