Patient Name: ____________________________ **Sugar Readings** Phone # _________________ DOB: ___________

EMAIL: Call@EndoMDs.com **Phone: 734-682-5243 OR 419-724-0004** **Fax: 888-677-1987**

Always Follow THIS Table

Insulin	Breakfast	Lunch	Dinner	Bed

\+

In Addition, WHEN SUGAR IS HIGH (only before meals), Add ________________ According to the scale circled below

Range	Low	Moderate	High
200-250	2 units	3 units	4 units
251-300	4 units	6 units	8 units
301-350	7 units	10 units	14 units
>350	10 units	16 units	20 units

Target Sugar: Before Meals: 80-130 | 2hr After Meals: < 140 | Anytime: <180

Date	Before Breakfast	2hr After Breakfast	Before Lunch	2hr After Lunch	Before Supper	2hr After Supper	Bed