

HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN

STUDENT WITH DIABETES ON INSULIN INJECTIONS

(MONTANA FORM VERSION 3/23/15)

EFFECTIVE DATE:	End Date:
STUDENT'S NAME:	Date of Birth:

DIABETES HEALTHCARE PROVIDER INFORMATION Name: _____

Phone #: _____ Fax #: _____ Email: _____

SCHOOL: _____ School Fax: _____

⇒ **See accompanying Algorithm for Blood Glucose Results as supplement to these orders*****

Monitor Blood Glucose: Check as needed for signs and symptoms of low or high blood glucose, or does not feel well.

<input type="checkbox"/> Before lunch	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Before PE	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Before leaving school	<input type="checkbox"/> Other: _____

Where to check: Anywhere Classroom Health office Other: _____

Insulin: Humalog/NovoLog/Apidra Other: _____

Insulin Delivery: Syringe/vial Pen

Carbohydrate Coverage:

Breakfast: Give 1 unit for _____ grams of carbohydrate **OR** Standard daily insulin injection (please describe): _____

AM Snack: Give 1 unit for _____ grams of carbohydrate _____

Lunch: Give 1 unit for _____ grams of carbohydrate _____

PM Snack: Give 1 unit for _____ grams of carbohydrate _____

Correction scale: **OR** **Correction Formula:**

BG Range: _____ Give _____ units BG Range: _____ Give _____ units BG Range: _____ Give _____ units BG Range: _____ Give _____ units BG Range: _____ Give _____ units BG Range: _____ Give _____ units	Give _____ units of insulin for every _____ mg/dl of blood glucose above target blood glucose of _____ mg/dl. Formula used to calculate correction: Blood glucose _____ minus (-) target blood glucose _____ = _____. Then divide (÷) by correction factor (_____) = _____.
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Give Correction Scale Before Lunch Only Other: _____

Do not give insulin correction dose more than once every 3 hours to prevent "stacking" insulin.

Check ketones if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when checked 2-3 hours apart.

- Use correction scale **OR** Use correction scale plus an additional _____ units for moderate and _____ units for large.
- Repeat ketone check in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

Exercise and Sports: Student should monitor blood glucose hourly Other: _____

Parent/Guardian Authority: To adjust insulin dose: Yes No
 To change frequency of blood glucose monitoring: Yes No

Diabetes Medications:

Glucagon (for emergency low blood glucose) - Dose: 0.5 mg 1.0 mg Given IM or SC per thigh or arm

Medication: _____ Dose: _____ Times to be given: _____

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HCP Assessment of Student's Diabetes Management Skills:	Notes:																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Skill</th> <th style="width: 20%;">Independent</th> <th style="width: 20%;">Needs supervision</th> <th style="width: 30%;">Cannot do</th> </tr> </thead> <tbody> <tr> <td>Check blood glucose</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Count carbohydrates</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Calculate insulin dose</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Injection</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p><input type="checkbox"/> Student may advance in independence through school year if school/parent agrees.</p>	Skill	Independent	Needs supervision	Cannot do	Check blood glucose				Count carbohydrates				Calculate insulin dose				Injection				
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HEALTHCARE PROVIDER	Date:
SIGNATURE/STAMP:	
Parent/Guardian	
Signature:	Date:

**UPDATES TO THE
HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN
STUDENT WITH DIABETES ON INSULIN INJECTIONS**

STUDENT'S NAME:	Date of Birth:
DIABETES HEALTHCARE PROVIDER INFORMATION Name:	
Phone #:	Fax #:
Email:	
SCHOOL:	School Fax:

**Effective
Date:**

Update:

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
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