

Diabetic Supply Form

Resident's Name: _____ DOB: _____

ICD: _____ Doctor: _____

PLEASE SIGN BELOW AND INITIAL NEXT TO EACH DIABETIC SUPPLY THAT IS NEEDED FOR THE CONTINUING CARE OF YOUR RESIDENT.

INITIAL	Diabetic Supplies	Qty.	Refills
	Syringe - Insulin 112cc or 1cc Micro Fine Needle 28G ½ inch (for use with insulin vials) Safety needles _____ Yes _____ NO Vanish point needles _____ Yes _____ NO	1 Box	11
	BD Auto shield Duo needles (for use with insulin pen)	1 Box	11
	Safety Lancets	1 Box	11
	Glucometer Strips	2 Boxes	11
	Alcohol Prep Pads	1 Box	11
	Glucometer	1	1
	Resident may keep Glucometer and all supplies in room or at bedside if resident chooses		
	Testing Frequency Per Day _____ PRN Testing Per Day- _____		

Substitute Permissible: _____

Doctor's Signature: _____

Doctor's Phone number: _____