

HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN

STUDENT WITH DIABETES USING INSULIN **PUMP** (MONTANA FORM VERSION 8/21/2015)

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 if student has symptoms of high or low 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 Pump Information: Humalog or NovoLog or Apidra by pump Other: _____

<p>Carbohydrate Coverage:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Give 1 unit of insulin per:</td></tr> <tr><td>_____ gm carbohydrate at breakfast</td></tr> <tr><td>_____ gm carbohydrate at AM snack</td></tr> <tr><td>_____ gm carbohydrate at lunch</td></tr> <tr><td>_____ gm carbohydrate at PM snack</td></tr> </table> <p>Bolus should occur: <input type="checkbox"/> before eating, or <input type="checkbox"/> other: _____</p>	Give 1 unit of insulin per:	_____ gm carbohydrate at breakfast	_____ gm carbohydrate at AM snack	_____ gm carbohydrate at lunch	_____ gm carbohydrate at PM snack	<p>Correction Bolus for Hyperglycemia:</p> <p>All blood glucose results should be entered into pump.</p> <p>Times given: <input type="checkbox"/> Before am snack <input type="checkbox"/> Before lunch <input type="checkbox"/> Before pm snack <input type="checkbox"/> Use pump suggested correction <input type="checkbox"/> Other: _____</p> <p>Give 1 unit of insulin for every _____ mg/dl, with a target blood glucose of _____ mg/dl.</p> <p>Formula used to calculate correction: Blood glucose _____ minus (-) target blood glucose _____ = _____. Then divide (÷) by correction factor (_____) = _____.</p>
Give 1 unit of insulin per:						
_____ gm carbohydrate at breakfast						
_____ gm carbohydrate at AM snack						
_____ gm carbohydrate at lunch						
_____ gm carbohydrate at PM snack						

Check Ketones if nauseated, vomiting or has abdominal pain, or if blood glucose > 300 twice when tested 2-3 hours apart.

Use correction formula via syringe/pen.
 Use correction formula via syringe/pen, and give an additional _____ units of insulin for moderate ketones, and _____ units for large ketones.

*** Repeat ketone check in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

* Basal insulin will be running continuously during school. Notes: _____
 * If infusion set comes out or needs to be changed: Insulin via syringe every 3 hours Change set at school

Moderate Exercise (lasting 30 minutes or more) and Sports with Pump:
 Temporary Basal Decrease: No Yes (_____ % for _____ minutes OR for duration of exercise)
 Student should monitor blood glucose hourly or when there are signs/symptoms of low/high blood glucose.

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

HCP Assessment of Student's Diabetes Management Skills:				Parent/Guardian Authority:
<i>Skill</i>	<i>Independent</i>	<i>Needs supervision</i>	<i>Cannot do</i>	* To adjust insulin dose: <input type="checkbox"/> Yes <input type="checkbox"/> No * To change frequency of blood glucose monitoring: <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:
Check blood glucose				
Count carbohydrates				
Deliver insulin bolus				
Change infusion set				
Calculate dose & inject				
Trouble shoot alarms, malfunctions				
<input type="checkbox"/> Student may advance in independence through school year if school/parent agrees.				

HEALTHCARE PROVIDER SIGNATURE/STAMP:	Date:
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PARENT/ GUARDIAN SIGNATURE:	Date:
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UPDATES TO THE HEALTHCARE PROVIDER ORDERS/DIABETES MEDICAL MANAGEMENT PLAN STUDENT WITH DIABETES USING INSULIN PUMP

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:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	

Healthcare Provider signature:	
Parent/Guardian signature:	