



This form needs to accompany Diabetes Center Referral Form

TO: _____ DATE: _____

FAX #: _____

Please sign the following orders given for: _____ D.O.B: _____
Patient Name

ORDERS:

BASAL

Initiate **Lantus** insulin _____ units. Circle am or pm. Increase Lantus by _____ units every three days until fasting blood glucose is _____ mg/dl (if left blank, will target 120 mg/dl).

Routine starting dose of LANTUS in patients with type 2 diabetes is 10 units (or 0.2 units/kg) once daily.

Other: _____

AND / OR:

BOLUS

Initiate rapid-acting insulin

(circle **Humalog, Novolog, Apidra**) insulin _____ units (fixed dose) within 15 minutes before each meal in addition to sliding scale to correct a high blood glucose (BG).

OR

Insulin to carbohydrate ratio (ICR) 1 unit per _____ grams CHO.

Insulin sensitivity factor (ISF) 1 unit to lower BG _____ points.

Target pre-meal BG _____ mg/dl.

PHYSICIAN / NP / PA Signature: _____

Thank you for your referral to our Diabetes Center.

Sincerely,

Susan Rauch, RN, BSN, CDE

FAX COMPLETED FORM TO:

**SJPMC DIABETES CENTER
FAX #: (208) 799-6520**

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