Addendum B
Travelers with Insulin-Controlled Diabetes

Traveler's Name _____ City and State _____

Exact name and brand of insulin used: Short acting: _____

Long acting: _____

The insulin is delivered via: ◯ Pen ◯ Syringe

Is insulin coverage for lunch taken: ◯ BEFORE or ◯ AFTER the meal?

Target blood glucose: Pre-Meal: _____mg/dl; 2 hours after meals: _____ mg/dl

Insulin Coverage for: Meals, Snacks & Long Acting Insulin

Meal/Snack	Time	Insulin: Carb ratio	Carb grams per meal	Type of insulin	Units of insulin	Is sliding scale present?
AM						◯ Yes ◯ No
Breakfast						◯ Yes ◯ No
AM Snack						◯ Yes ◯ No
Lunch						◯ Yes ◯ No
PM Snack						◯ Yes ◯ No
Dinner						◯ Yes ◯ No
Bedtime						◯ Yes ◯ No
Night						◯ Yes ◯ No

Sliding Scale

Sliding Scale: The amount of insulin used to cover an elevated blood glucose **over** the amount of insulin used to cover meals.

Correction Factor Formula (if used) (Blood Glucose – Target ÷ Sensitivity
(Blood Glucose - _____ ÷ _____)

If Blood Glucose is less than _____ mg/dl = Give **NO Sliding Scale Insulin**

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose above _____ mg/dl give _____ Units