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 & <u>Long Acting</u> 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 **<u>over</u>** the amount of insulin used to cover meals.

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

If Blood Glucose is less than ____________ mg/dl = Give **<u>NO</u> 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

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