

## WEEKLY DOCUMENTATION - INSULIN

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**Resident Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Insulin type: \_\_\_\_\_ Dosage: \_\_\_\_\_

Insulin Coverage: (if ordered) \_\_\_\_\_

Able to self-administer Insulin safely: YES [ ] NO [ ] DOES NOT self-administer [ ]

Diet Order: \_\_\_\_\_ Dietary Compliance: [ ] YES [ ] NO

LOC: AAO x 3 [ ] Forgetful [ ] Confused [ ] Disoriented [ ]

Weekly Blood Sugar Ranges: Highest \_\_\_\_\_ Lowest \_\_\_\_\_

Signs/Symptoms of Hyperglycemia/Hypoglycemia: \_\_\_\_\_

\_\_\_\_\_.

c/o Neuropathy (hands/feet) \_\_\_\_\_.

Edema - extremities: \_\_\_\_\_ TED Hose: [ ] YES [ ] NO

Skin Wounds: \_\_\_\_\_.

Vision: WNL [ ] Cataracts [ ] Macular Degeneration [ ]

Notes – Concerns: \_\_\_\_\_

\_\_\_\_\_ **RN Signature:** \_\_\_\_\_

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