Division of Pediatric Endocrinology
1601 4th Avenue South
CPP II, M30
Birmingham, AL 35233
(205) 638-9107
(205) 638-9821 (fax)
www.peds.uab.edu
www.health.uab.edu
www.childrensal.org

THE CHILDREN'S HOSPITAL DIABETES CENTER
FAX COVER SHEET FOR BLOOD SUGAR MANAGEMENT

OFFICE PHONE (205) 638-9107
OFFICE FAX (205) 638-9821

TODAY'S DATE: ____

CHILD'S NAME: ____

DATE OF BIRTH: ____

EVENING PHONE NUMBER: ______________________________
(please include area code)

CELL PHONE NUMBER: _________________________________
(please include area code)

ATTENTION:

Dr. Hussein Abdullatif ___________
Dr. Ambika Ashraf ___________
Dr. Joycelyn Atchison ___________
Dr. Caroline Colvin ___________
Dr. Alexandra Martin ___________
Dr. Shelly Mercer ___________
Dr. Kenneth McCormick ___________
Dr. Gail Mick ___________
Dr. Mary Lauren Scott ___________
Dr. Michael Stalvey ___________
Ava Mitchell, DNP CRNP ____________
Leslie Pitts, CRNP ___________

Diabetes Educators

Heather Armstrong, RN __________
Melissa Ashdown, RN ___________
Sheila Benton, RN, CDE ___________
Kellie Caples, RN ___________
Deborah Chadwick, RN ___________
Nicole Chilton, RN, CDE ___________
Becky Earman, RN, CDE ___________
Kristin Ezekiel, RN, CDE ___________
Shamblin Griffice, RN, ___________
Renee Hall, RN, CDE ___________
Jasmine Hartfield, RN ___________

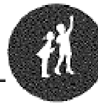
Lori McAuley/ Pamela Melton, Social Workers ____________
Registered Dietitian ____________

****ONLY USE THIS FAX SHEET FOR ROUTINE CONCERNS/BLOOD SUGAR ADJUSTMENT****

Number of page including cover sheet: ______

Revised MAR2016

UAB HEALTH SYSTEM
Department of Pediatrics

In affiliation with  CHILDREN'S HEALTH SYSTEM®

Format to FAX Blood Sugars

Date: _____________ Diabetes Doctor: ______________________

Child's Name: ___________________________________Age: _______ Date of birth: ____________

Caregiver's Name: ____

Home Phone: ___________ Work Phone: ___________ Cell Phone: __________FAX# __________

** **IMPORTANT** ⇒ **Please complete** { Child missed _____**days of school** last week related to diabetes;
Behavior changes noticed over last 2 weeks? **(Circle one) Yes / No**

Current Dose

Average amount of carbohydrates each meal and snacks (if applicable): ___Breakfast/ ____lunch/ ____Supper/ ____snacks

Correction Formula (if applicable): ____

Medication(s)	**Morning**	**Lunch**	**Supper**	**Bedtime**	**Snack**
Humalog/ Apidra\ Novolog	________	________	________	________	________
Lantus or Levemir	________	________	________	________	________
Metformin (Glucaphage)	________	________	________	________	________
Byetta / Symlin	________	________	________	________	________
Other: _________________	________	________	________	________	________

Main Concern(s): ____

** **Ketones present: _____No; _____ trace; _____ small; _____ moderate; _____ large**

List any frequent special activities and times (for example: Dance class 3-5 Mon., Wed., Friday or sports, etc.).

____

Blood Sugar Readings

Date	Before Breakfast	Mid-Morning	Before Lunch	Mid Afternoon	Before Supper	Before Bed	During the Nighttime

CONFIDENTIALITY & HIPAA PRIVACY NOTICE: Protected Health Information may be enclosed

IMPORTANT: This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

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