Patient Name _____ **Date of Birth** _____
Due Date _____
Please **photo** and **email** to Angelique Martin, RD at
Angelique.Martin@perinatalcenter.com or
Emily Lawrance, RD at Emily.Lawrance@perinatalcenter.com
Fax Information (Please send to the clinic where you have your visits):
Mercy 405-607-8761, Baptist 405-606-2855, Norman 405-801-2564
Tulsa 918-746-2230

THE PERINATAL CENTER
MATERNAL-FETAL MEDICINE

Treatment Plan:
Diet Only ____ Diet and Glyburide or Metformin ____ Morning Dose: ___ mg Evening Dose: ___mg

Diet and Insulin Therapy:

Type of Insulin: _____AM dose:____, Lunch dose: _____, PM dose:_____

Type of Insulin: _____ AM dose: ____, Lunch dose: _____, PM dose: _____

Directions:
Indicate Blood Sugar recordings below when you wake up (fasting) before breakfast and 1 hour or 2 hours after meals (per the provider's unique instructions for your care)

Date						
Fasting	Post-Breakfast	Pre-lunch	Post-lunch	Pre-dinner	Post-dinner	3 AM
Date						
Fasting	Post-Breakfast	Pre-lunch	Post-lunch	Pre-dinner	Post-dinner	3 AM
Date						
Fasting	Post-Breakfast	Pre-lunch	Post-lunch	Pre-dinner	Post-dinner	3 AM
Date						
Fasting	Post-Breakfast	Pre-lunch	Post-lunch	Pre-dinner	Post-dinner	3 AM
Date						
Fasting	Post-Breakfast	Pre-lunch	Post-lunch	Pre-dinner	Post-dinner	3 AM
Date						
Fasting	Post-Breakfast	Pre-lunch	Post-lunch	Pre-dinner	Post-dinner	3 AM
Date						
Fasting	Post-Breakfast	Pre-lunch	Post-lunch	Pre-dinner	Post-dinner	3 AM

*****Blood glucose goals for pregnancy: Fasting 60-90 mg/dl, 1 hour after meals <140 mg/dl, 2 hours after meals <120 mg/dl**