Bedford Commons, OB/GYN

Please call or fax in blood sugars twice weekly:

Phone: 603-668-8400 Fax: 603-626-7368 Email*: triage@bcog.com

☐ **Diet controlled**

☐ **Insulin Dependent** (please document current insulin dosing and insulin type below)

Blood Glucose Tests

Name _____ ***DOB***_____

Date	**FBS**	*AM Meds/ insulin*	**1 hr. BS after breakfast**	*Before lunch Meds/ insulin*	**1 hr. BS after lunch**	*Before dinner Meds/ insulin*	**1 hr. BS after dinner**	*PM Meds/ insulin*	**comments**

Gestational Diabetes Guidelines

Fasting 60-94 mg/dl Before meals 90-100 mg/dl 1 hours after meals <140 mg/dl

***Please note that email is NOT encrypted.** By emailing the blood glucose form, you take responsibility for your protected health information. The only protected form of transmitting health information electronically is to encrypt it prior to sending.

Last updated 7/2018