

**Children's Medical Center of Dallas**  
 1935 Motor Street Dallas, Texas 75235 (214) 456-7000  
**ENDOCRINOLOGY CENTER**  
**Blood Glucose Log**

Med Rec No. \_\_\_\_\_ Acct. No. \_\_\_\_\_  
 Patient: \_\_\_\_\_  
 Date: \_\_\_\_\_ **LABEL** Location: \_\_\_\_\_  
 DOB: \_\_\_\_\_

Month \_\_\_\_\_ Year \_\_\_\_\_ Please mail to address listed above or send form via Fax to: (214) 456-5963  
 Phone H: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ W: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Secure Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Day of Month	Breakfast		Lunch		Dinner		Bedtime		Patient/Parent Comments
	Blood Gluc	Insulin /Dose	Blood Gluc	Insulin /Dose	Blood Gluc	Insulin /Dose	Blood Gluc	Insulin /Dose	
1									
2									
3									
4									
5									
6									
7									
8									
9									
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30									
31									

Treatment Interventions:   	<b>Endocrine Office Use Only</b>   Physician Signature _____ Date _____ Staff Signature _____ Date _____
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