Diabetes Management Plan

Client Name: DOB: _____ Address: _____ Phone: _____ Emergency Contact Name & Number: _____ _____	Name of Doctor: _____ Phone: _____ Address: _____ Allergies: _____ _____ Plan Effective Date: _____ Review Date: _____

Diabetes Type:

☐ Type 1 (Insulin Dependent)

☐ Type 2 - Non Insulin Dependent
(Oral Medication & Diet Controlled)

☐ Type 2 – Non Insulin Dependent
(Diet Control Only)

Frequency of BGL Measurement: _____

Accepted range of BSL: _____

Plan for Measuring BGL (if staff assistance is required): _____

_____

_____

_____

Management of BGL if lower than range indicated: _____

_____

_____

_____

Management of BGL if higher than the range indicated: _____

_____

_____

_____

Dietary Management Guidelines: _____

_____

_____

_____

_____

Plan Approved By:

GP**:**

Signed:_____ Dated: _____

Parent/Guardian**:**

Signed: _____ Dated: _____

Co-ordinator**:**

Signed: _____ Dated: _____

To be signed by each staff member working with this client, including regular casuals:

Name: _____ Signature: _____ Date: _____
Name: _____ Signature: _____ Date: _____
Name: _____ Signature: _____ Date: _____
Name: _____ Signature: _____ Date: _____
Name: _____ Signature: _____ Date: _____
Name: _____ Signature: _____ Date: _____
Name: _____ Signature: _____ Date: _____
Name: _____ Signature: _____ Date: _____