Diabetic Medication Reconciliation Form:

MPatient Name: _____ Surgery Date: _____

Physician Name: _____ Post op-primary md visit date/time:_____

Medication BEFORE Surgery				
Diabetic Medication	**Dosage**	**Route/ Frequency**	**Notes/ Other**	

Medication AFTER Surgery				
Diabetic Medication	**Dosage**	**Route/Frequency**	**Notes/ Other**	

NOTES:_____

_____

Physicians Signature:_____ Date:_____

SYMPTOMS AND TREATMENT OF HYPOGLYCEMIA

TREAT SYMPTOMS USING 15 RULE
15 GRAMS OF CARBS
(3-4 glucose tabs or packets of sugar)
WAIT 15 MINUTES
RECHECK BLOOD SUGAR
(If below 70 then repeat above)

I am aware that it is likely that my current diabetic regimen with change following surgery. I understand that it is my responsibility to communicate with my primary care physician regarding symptoms as well as instructions regarding medication adjustment. I understand once a surgery date is confirmed, I will schedule a follow up appointment with my physician within 3 days following surgery. I understand importance of monitoring glucose twice a day and to maintain a log of my readings to provide to my physician on my follow up visit.

Patient Acknowledgement: _____ Date:_____

THIS FORM MUST BE COMPLETED IN ENTIRETY PRIOR TO SURGERY AND FAXED TO THE SURGEON'S OFFICE AT 504-349-6865 AND INCLUDE FORM IN HOSPITAL H&P.

Revised 03/13/2018