**GESTATIONAL SUGAR SHEET**

***Southeastern Endocrine Diabetes***
1475 Holcomb Bridge Road Ste 129 * Roswell, GA 30076 * 678-325-250 * 678-325-2261 fax

**GESTATIONAL SUGAR SHEET**

Doctor: _____

Name: _____

Address: _____

Work #: _____

Home #: _____

BG Target Goal _____ to _____

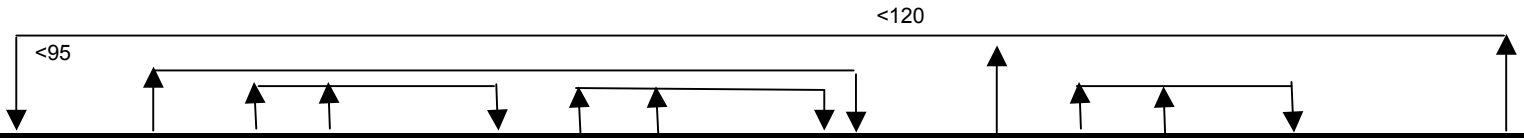
Supplemental Formula ≥ **120** **BG-80/20**

Weeks Gestation _____

Estimated Due Date _____

Notes _____

# GESTATIONAL SUGAR SHEET




| Date | Ketones | | Pre-Breakfast | | | | | | Pre-Lunch | | | | | Pre-Supper | | | | | | Bedtime | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | BG | | Reg | Supp | 2 Hr | Supp | BG | Reg | Supp | 2 hr | Supp | BG | | Reg | Supp | 2 hr | Supp | B.G. | |
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**It is the responsibility of the patient to contact a member of the diabetes team with 3 or more blood sugars > 120 mg/dL**

Notes: _____