GROUP HEALTH CENTRE
ALGOMA DIABETES EDUCATION & CARE PROGRAM
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NDHN MEMBER PROGRAM

DIABETES MEDICATION ADJUSTMENT ORDER FORM

Patient Name: _____

Current Diabetes Medication(s): _____

Medication (Name)	Dose/Freq	Continue	If Continued, New Dose/Freq.	Discontinue	Date to Discontinue
		☐		☐	
		☐		☐	
		☐		☐	
		☐		☐	

Insulin (type, dosage, frequency, time):

Special Instructions:

Authorization for Insulin Dose Adjustment: ☐ Yes ☐ No

Authorization for Oral Dose Adjustment: ☐ Yes ☐ No

Prescription for Insulin and Supplies: ☐ Provided (given to patient)

☐ To provide after assessment appointment for Insulin start.

Date _____ Physician's Signature _____

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Based on DCPNS Insulin Dose Adjustment Policies & Guidelines Manual - April 2002