Central West Common Insulin Order Set

Stand UP to Diabetes
Faisons face au diabète

Name: _____ **Sex:** M☐ F☐ **DOB:** ____/____/____ (MMM / DD / YYYY)

Address: _____

City: _____ **Postal Code** _____ **Health Card #:** _____

Phone (H) _____ **(W)** _____

Patient Primary Language Spoken: _____ **Translation Required?** Yes☐ No☐

Has Family MD? Yes☐ No☐ **OK For Group Education?** Yes☐ No☐

INSULIN TYPE				DOSING & TITRATION
BASAL		☐ **Levemir®** ☐ Cartridge	☐ **Lantus®** ☐ Cartridge ☐ Vial ☐ SoloSTAR™	Starting Dose: _____ units ac bedtime Increase dose by _____ units every _____ nights until fasting blood glucose has reached the target of _____ mmol/L
Long-acting analogues (Clear)				
Intermediate-acting (Cloudy)	☐ **Humulin® N** ☐ Cartridge ☐ Vial ☐ Prefilled Pen	☐ **Novolin® ge NPH** ☐ Cartridge ☐ Vial		
PRANDIAL	☐ **Humalog®** ☐ Cartridge ☐ Vial ☐ Prefilled Pen	☐ **NovoRapid®** ☐ Cartridge ☐ Vial Limited Use ☐ 388 (type 1 DM) ☐ 389 (type 2 DM)	☐ **Apidra™** ☐ Vial ☐ SoloSTAR™	Starting Doses: _____ units ac breakfast _____ units ac lunch _____ units ac supper
Rapid-acting analogues (Clear) ** GIVE IMMEDIATELY BEFORE MEAL **				
Short-acting (Clear) ** GIVE 30 MINUTES BEFORE MEAL **	☐ **Humulin® R** ☐ Cartridge ☐ Vial	☐ **Novolin® ge Toronto** ☐ Cartridge ☐ Vial		
PREMIXED (BASAL + BOLUS)	☐ **Humalog® Mix25®** ☐ Cartridge ☐ Prefilled pen ☐ **Humalog® Mix50®** ☐ Cartridge	☐ **NovoMix® 30** ☐ Cartridge		Starting Doses: _____ units ac breakfast _____ units ac supper Increase breakfast dose by _____ units every _____ days until presupper blood glucose has reached the target of _____ mmol/L Increase presupper dose by _____ units every _____ days unitl fasting blood glucose has reached the target of _____ mmol/L ***Beware of hypoglycemia post-breakfast or post-supper. Stop increasing dose if this occurs.***
Premixed analogues ** GIVE IMMEDIATELY BEFORE MEAL **				
Premixed regular ** GIVE 30 MINUTES BEFORE MEAL **	☐ **Humulin® 30/70** ☐ Cartridge ☐ Vial	☐ **Novolin® ge 30/70** ☐ Cartridge ☐ Vial ☐ **Novolin® ge 40/60** ☐ Cartridge ☐ **Novolin® ge 50/50** ☐ Cartridge		

ORAL ANTI-HYPERGLYCEMIC AGENTS	
	☐ Start _____
	☐ Continue _____
	☐ Discontinue _____

My signature authorizes, as per Organization's Medical Directives, the Registered Nurse and/or Registered Dietitian to:

☐ **reduce and/or discontinue the secretagogue dosage accordingly to avoid hypoglycemia**

☐ **adjust insulin dose by 1-2 units or up to 20% prn to achieve CDA CPG glycemic target of ac 4-7mmol/L and pc 5-10mmol/L or individual target of:** _____

Referring Physician: _____

Signature: _____ **Referral Date** ____/____/____ (MMM / DD / YYYY)