Phone/Email Follow Up

Patient Label

Referring Physician: _____

Date: _____

Blood Sugar Assessment							
AC Br	PC Br	AC Lu	PC Lu	AC Su	PC Su	HS	Other

Assessment (Diet, Activity, Other)	Notes
	Recommendations

Next Follow-Up			
Clinic:	☐____ **Weeks**	☐ ____ **Months**	☐ **NONE**
Phone/Email:	☐ ____ **Days**	☐____ **Weeks**	☐ **PRN**

Educator: _____ **Date:** _____