**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:** _____