

Patient-Determined Insulin Dosing Consent Form

If you would like to manage your own insulin doses while you are in the hospital, you must follow the guidelines below. This is to make sure your diabetes is safely managed. If, for any reason, you no longer want to choose your own insulin doses please tell your nurse or doctor right away. Your insulin doses will then be ordered by your doctor.

Please read the conditions stated below the line. If you agree, sign at the bottom of the form.

I wish to choose my own insulin doses during this hospital stay. I understand that being in the hospital and the stress of illness may lead to unexpected changes in my blood sugar. I may not be used to managing these unexpected changes in my blood sugars.

During my hospital stay I agree to:

- Determine my own insulin doses. I know that being sick and in the hospital can increase my chances of having
 - high blood sugar,
 - low blood sugar,
 - diabetic ketoacidosis,
 - infection.
- Use the hospital insulin and injection supplies, according to hospital policy.
- Have my blood sugar checked using the hospital glucose meters and lancets, and according to hospital policy. I may use my blood glucose meter for any other tests that I check myself.
- Report to the nurse, all insulin doses I give myself.
- Let the nurse know immediately if:
 - I feel like I have low blood sugar
 - I no longer want to choose my own insulin doses

I understand that my doctor may decide to choose my insulin doses for me if:

- There is a change in my mental state and I am not able to safely choose my own insulin doses.
- My blood sugar levels or A1C are too high or too low
- I am going to have a procedure
- There is any other reason stated by my doctor.

The guidelines for choosing my own insulin doses have been explained to me. I have had an opportunity to fully inquire about the above guidelines. I understand the above guidelines. I feel that I am able to safely choose my own insulin doses while in the hospital.

Date _____ Time _____ Patient Signature _____

Date _____ Time _____ Physician _____ MD CID

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