



ENDOCRINOLOGY & DIABETES PROGRAM

Phone: _____ Fax: _____

Endocrinologist: _____ Nurse: _____

BLOOD GLUCOSE LOG FOR HYPERINSULINISM

Name: _____ Date of Birth: _____

Contact Name and Phone Number: _____

Date/Time	Blood Sugar	Feeds		Octreotide	Diazoxide	Comments
		Mouth	Tube			