DIABETIC FLOW SHEET							
Day of	AM	PM	Before	Before	Before	Before	Comments
Month	Insulin	Insulin	Breakfst	Lunch	Dinner	Bed	
1							
2							
3							
4							
5							
6							
7							
8							
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21							
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26							
27							
28							
29							
30							
31							
Please Aver							Please be sure to include your
for the month at each time							medication doses if you call in or FAX in your record sheets.