Blood glucose testing

See attached recording sheet below

Important to test at the right times...see bottom left corner of recording sheet

- Test 4 times per day. Test BEFORE breakfast and 2hrs AFTER each meal.
- Time the 2 hours from when you START eating and THEN have your snack
- For example, if you start eating breakfast at 7.30am do your test at 9.30am

Disposal of prickers
Put in hard plastic container – e.g. laundry detergent bottle, dishwasher detergent bottle, honey jar, marmite jar (not milk bottle). When baby is born place container in the rubbish.

Tips for gentle blood sampling
You can use the same needle in your pricker for 3 or 4 days. (NO NEED TO CHANGE AFTER EVERY TEST)

<table>
<thead>
<tr>
<th>Ensure your hands are clean and dry</th>
<th>Prick on the side of the fingertip instead of the pad</th>
<th>Select a depth as shallow as possible that still produces blood</th>
<th>Ensure you alternate fingers daily</th>
</tr>
</thead>
</table>

These steps have been taken from the ACCU-Chek Multiclix – Your step-by-step guide
### Auckland District Health Board

Park Road, Auckland, Telephone 0-9-379 7440

<table>
<thead>
<tr>
<th>Pharmacy use only</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Item Count</td>
<td>Subsidy Card</td>
</tr>
</tbody>
</table>

- **Auckland Hospital**
- **Greenlane Clinical Centre**
- **Other** [Please specify]

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**Prescription Form**

**Circle one from each line**

<table>
<thead>
<tr>
<th>Y</th>
<th>J</th>
<th>A</th>
<th>O</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Z**  
(Circle if patient has High Use Health Card)

**NS**

- **NHI Number**
- **Date of Birth**
- **If patient under 13**
- **Payer Number**
- **Please specify**

**Doctor’s Name (PLEASE PRINT)**

**NZMC Reg. No.**

**Full Residential Address of Patient**

**Pharmacy Stamp**

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**Patient Information**

- **Care Sens N Blood glucose meter**
  - newly diagnosed GDM
- **Care Sens N Test Strips**
  - 6 tests per day
  - 3/12

**Certified Extended Supply:**

<table>
<thead>
<tr>
<th>Period</th>
<th>Quantity</th>
<th>Disp. Date</th>
<th>Dispensing Date</th>
<th>Pharmacist</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1st</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2nd</td>
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<tr>
<td></td>
<td></td>
<td>3rd</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature of Prescriber**

<table>
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</thead>
</table>

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Before breakfast aim for 4.0 - 5.0 mmol/L (average less than 5.0 mmol/L)
After meals (2 hours from start of eating) aim for 4.5 - 6.5 mmol/L (average less than 6.0 mmol/L)

<table>
<thead>
<tr>
<th>DATE</th>
<th>INSULIN INJECTIONS</th>
<th>MONITORING BLOOD</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>type of insulin</td>
<td>before bed</td>
<td>before bed</td>
</tr>
<tr>
<td></td>
<td>pre b'fast</td>
<td>pre lunch</td>
<td>pre dinner</td>
</tr>
</tbody>
</table>

WHEN YOU COME INTO HOSPITAL PLEASE BRING IN ALL TESTING EQUIPMENT AND YOUR RECORD BOOK. IF YOU ARE ON INSULIN PLEASE BRING ALL YOUR INSULIN AND PENS.

1. TEST BEFORE BREAKFAST
2. 2 HOURS AFTER BREAKFAST FROM START OF EATING
3. 2 HOURS AFTER LUNCH FROM START OF EATING
4. 2 HOURS AFTER EVENING MEAL FROM START OF EATING

DIABETES CLINIC HOURS 8AM TO 4PM MONDAY TO FRIDAY
Ph: 307 4949
Fax: 307 4918

PLEASE PHONE YOUR DIABETES MIDWIFE _______________________________ EXT: _____________

OR EMAIL ____________________________________ AT LEAST ONCE WEEKLY WITH YOUR RESULTS