

Obstetric Guidelines

SUBJECT: DIABETES MELLITUS

PART 1: Gestational Diabetes

A. Overview

Gestational diabetes is defined as carbohydrate intolerance first diagnosed or recognized during pregnancy. It represents a condition of increased peripheral resistance to insulin that becomes clinically manifested only during pregnancy. A significant number of these women will develop overt diabetes later in life. It is associated with an increased perinatal morbidity.

B. Detection

All women should be screened (1 hour glucola) for diabetes during pregnancy at 24-28 weeks.

Patients with significant historical risk factors should have a diabetes screen at their initial visit. A repeat 1 hour glucola test should be performed at 24-28 weeks if the initial test is negative. If the pre 24-week screening 1hour glucola test is abnormal, the repeat test should be a 3-hour glucose tolerance test.

Following are those risk factors for which initial visit glucose screening is warranted:

1. Prior infant birth weight greater than 4500 kilograms (~10 lbs.)
2. Patient reports history of impaired glucose tolerance or impaired fasting glucose
3. Prior unexplained stillborn or anomalous infant
4. Previous pregnancy complicated by gestational diabetes
5. Maternal age greater than 40
6. Maternal extreme obesity (~BMI >40.0)
7. Polycystic ovarian syndrome (PCOS) patients without a recent normal glucose screen

C. Screening Test

- One- hour plasma glucose determination following a 50 gram oral glucose load
 - The patient need not be fasting when this test is performed.
 - A glucose >140 defines an abnormal screen.
 - Patients with an abnormal screen require a 3-hour glucose tolerance test (OGTT).
 - If the screening test value is greater than 200, the patient should be treated as if she has gestational diabetes.

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D. 3-hour OGTT (100 gram):

1. All patients must be fasting for 8 hours prior to obtaining the first sample. A three-day carbohydrate load is preferred (150 grams per day). See patient instruction sheet in Appendix.
2. Criteria for interpretation of an abnormal test:

	Fasting	1hr	2hr	3hr
Plasma	95	180	155	140mg/dl

*Two or more abnormal values are considered a positive test.

** If the fasting is >126, the criteria for diabetes is met.

E. Management of Gestational Diabetes

Management consists of diet, exercise and monitoring of glucose values by the mother at home. If glucose values are persistently elevated despite these measures, further therapy with oral hypoglycemic agents or insulin should be initiated.

1. Diet:

Composition: Protein 20-30%, Carbohydrate (CHO) 40-50%, Fat 20-30%

Calories:

- 25-35 kcal/kg of adjusted body weight (ABW)
 - Calculation of adjusted body weight
 - Current weight minus ideal body weight (IBW)
 - Multiply the difference by 25% to find the 'metabolically active overweight tissue' and add that value back to IBW
 - Use new ABW to calculate kcal/day
 - Example:
 - 5' 2" female IBW = 110#
 - Actual weight 210# - 110# = 100#
 - 100# x .25 = 25#
 - 25# + 110# = 135# ABW
 - 135# /2.2 = 61kg x 30kcal = 1840 or 1850kcal/day
- 25 weeks add: 300 additional kcal for singletons and at least 600 kcal for multiples.
- Examples of sick day diet recommendations for gestational and insulin dependent diabetics are found in the Appendix.

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2. Exercise:

Encourage moderate exercise daily (if no contraindications) or at least 3-4 times per week for 20-30 minutes per session. Brisk walking is recommended.

3. Glucose monitoring and management of abnormal values:

- Fasting and 2 hour postprandial with every meal by glucose meter
- Review glucose meter results in patient record book each visit.

If the patient has more than half abnormal values:

- She should be evaluated for compliance with diet, re-working the diet to meet her needs and,
- If that still fails, oral hypoglycemic or insulin therapy should be initiated as outlined below for use in pregestational diabetes.
 - Oral Hypoglycemic study available to evaluate glyburide vs. metformin vs. insulin.
Exclusion criteria include:
 - GA <12 weeks or >34 weeks
 - Juvenile onset diabetes
 - History of microvascular complications from diabetes
 - Known renal compromise
 - Severe asthma
 - **Current recommendations advocate metformin use in clinical trials only. Patients who have been on metformin for PCOS or other infertility criteria should discontinue its use.**
 - An alternative to insulin for gestational diabetes is the oral hypoglycemic agent glyburide. **Glyburide use in the 1st trimester has not been studied and should be avoided.** Other oral hypoglycemics have not been studied well and/or cross the placenta and should not be used.
 - If glyburide is chosen:
 - The initial dose is 2.5 mg bid which may be increased to 20 mg per day.
 - The main reason for discontinuation of this drug is suboptimal control which occurs in up to 10 % of patients.
 - Insulin should be initiated if control is not achieved with glyburide.
 - Patients needing therapy <30 wks, FBS >110 or 1hr PP >140 are at high risk for failure and insulin therapy should be considered. (See Part II: Pregestational Diabetes C. Management 2. Insulin)

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A growth ultrasound can assist in management.

- If the abdominal circumference is >2 SD (or $>75\%$ EFW) or evidence of polyhydramnios is present, then the current therapy is suboptimal and should be revised.
4. Documentation: **Record all data in MARS – use MARS diabetic record** (see Appendix)
 5. Antenatal Fetal Surveillance: (See Guideline A 1.30).
 6. Delivery: Gestational diabetics on medical therapy should be offered delivery at 39-40 weeks. Those patients well controlled on diet may continue pregnancy until 40-41 weeks.

PART 11: PREGESTATIONAL DIABETES MELLITIS

II. Pregestational Diabetes Mellitus

A. Overview

Insulin-dependent diabetes mellitus represents a high risk perinatal condition. Good Perinatal outcomes can be obtained in most cases. Patients diagnosed with “gestational diabetes” prior to 20 weeks’ gestation may in fact be previously undiagnosed diabetics. These patients should be managed as if they had diabetes prior to pregnancy.

B. **White’s Classification of Diabetes in Pregnancy**

Table from Gabbe, Niebyl, Simpson, 2006

Class	Age of Onset (years)		Duration (Years)	Vascular Disease	Insulin
A	Any		0	0	
B	>20		<10	0	
C	10-19	OR	10-19	0	+
D	<10	OR	>20	Benign retinopathy	+
F	Any		Any	Nephropathy	+
R	Any		Any	Proliferative retinopathy	+
T	Any		Any	Transplant	+
H	Any		Any	Heart Disease	+

C. **Management of Pregestational Diabetes Mellitus**

1. Diet and Exercise

Described above under “Diet Controlled Gestational Diabetes”

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2. Laboratory Evaluation

The following should be obtained at the first prenatal visit:

- a. Urine dipstick and urine culture
- b. Hemoglobin A_{1c}
- c. 24-hour urine for protein and creatinine clearance determination, serum creatinine
- d. Baseline EKG

3. Ultrasound Examinations

- a. Obtain an ultrasound (US) scan at the first prenatal visit as accurate dating is important.
- b. There is an increased incidence of congenital anomalies in pre gestational diabetics. Obtain serum screening and then a level II US at 18-22 weeks gestation.
- c. Follow-up US for growth recommended every month after 28 weeks.
- d. Fetal Cardiac Echo recommended at approximately 22 wks gestation.
- e. Late third trimester US for macrosomia (after 36 weeks)

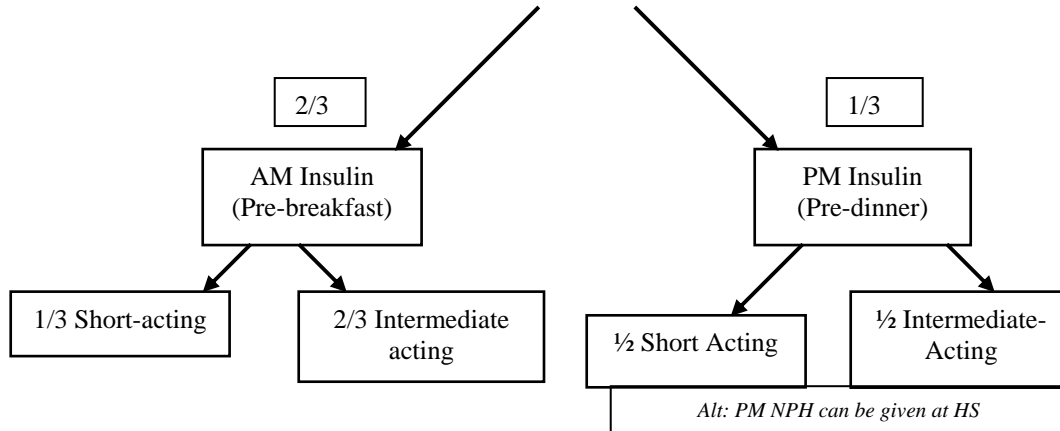
4. Insulin:

Initiate insulin therapy in pre gestational and gestational diabetics as follows:

- a. Initial dose of **weight based** insulin is determined by actual body weight and gestational age.
The total daily dose is calculated as:
 - 0.7 units of insulin per kg in first trimester
 - 0.8 u/kg in second trimester
 - 0.9 u/kg in third trimester
- b. Divide insulin dose into 2 injections:
 - 2/3 of total dose in am (prior to breakfast)
 - 1/3 total dose in pm (prior to dinner)
- c. Composition of insulin dose is:
 - Morning - 2/3 NPH & 1/3 regular
 - Evening - 1/2 NPH & 1/2 regular
- d. If good control is not achieved, adjust the dose accordingly. **Often it is necessary to divide the evening dose and administer the evening NPH each bedtime instead of before meals.**

Total Calculated Weight-Based Insulin

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Insulin pump therapy in pregnancy (Management per MFM or Endocrine team):

1. Pump starts – Calculate total daily insulin (TDI) needs (either from above or total insulin patient is currently on).

- a. **Basal Rates:** $TDI \times 0.75-0.8 = TDI_{Pump} (TDI_P)$
 $\frac{1}{2} TDI_P = Basal/24 = 1 \text{ h Rate}$
- b. **Boluses (CHO:I Ratio):** *(grams CHO per unit insulin)*
Rule of 500 = $500 / \frac{1}{2} TDI_P$
- c. **Sensitivity:** *(How much BS decreases per unit of insulin)*
Rule of 1500 = $1500 / \frac{1}{2} TDI_P$

2. Bolus Wizard Settings:

Carb Units:	grams
Carb Ratio:	see b above
BG Units:	mg/dL
Sensitivity:	see c above
BG Target:	100-100
Active Ins Time:	5

3. Pump adjustments: Initially, patient should be checking 3AM (random), pre and postprandial blood sugars to assess appropriate basals and boluses. **Most people will need 2-3 basal settings.**

- a. If pre-prandial blood sugars are abnormal, basal rate should be adjusted approximately 2-3 hrs prior to time needed to be adjusted.

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- b. If postprandial blood sugars are abnormal, CHO:I ratio needs to be adjusted.
- c. **Should not make more than 10% corrections at one time.**

4. Glucose Monitoring: patient performs at home.

- Blood glucose should be checked by the patient **at least** 4 times per day, fasting, 2 hours after patient starts eating breakfast, lunch and dinner.
- Additional blood glucose checks prior to lunch, prior to dinner, prior to the evening snack, and at 3 AM may be indicated.
- Goals for therapy are:
 - Fasting 60-90
 - 1 hour PP < 140
 - 2 hour postprandial glucose < 120
- These values should be recorded by the patient in a log book that she should bring to the clinic each visit for review by the physician.
- The patient should bring her glucose meter to clinic each visit. Planning is underway to initiate download of glucose meter readings at each patient's clinic visit.

5. Consults as indicated

- a. Ophthalmology
- b. Dietician
- c. Anesthesia (pre delivery)
- d. Endocrine (insulin pump patients)

6. Antenatal Fetal Surveillance [guideline A 1.30]

Fetal kick counts should be started at 26-28 weeks gestation on all diabetic patients
[Creasy/Resnick 2004 p.1053]

7. Delivery

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- If patient has excellent control with good dating, induction/delivery may be provided at 39-40 weeks without documentation of fetal lung maturity. **Amniocentesis should be reserved for those patients to be delivered earlier, e.g. with poor dating or with poor glucose control.**
 - Consider delivery when PG (phosphatidyl glycerol) is present in amniotic fluid or FLM >50.
 - Discuss elective cesarean section for macrosomia (ultrasound EFW: ≥ 4500 grams).
8. Diabetic Day of Delivery Guideline - Patients undergoing scheduled cesarean section or induction of labor
- On the evening preceding elective cesarean or induction, the usual evening dose of regular insulin and NPH is administered. Initiate NPO at midnight.
 - Give all insulin intravenously or via insulin pump on the day of induction/cesarean delivery.
 - For all patients start 5% dextrose/0.45 NS or D5LR to run at 125 ml/hour. Other intravenous fluid needs should be met with non-dextrose containing solutions.
 - If the glucose level is greater than 250, use normal saline until the glucose level is less than 250.
 - If patient is managed with an insulin pump during labor, non-dextrose containing intravenous fluids may be used unless blood sugars dictate otherwise.
 - For all patients undergoing an induction:
 - During cervical ripening if the patient is eating, may give ½ dose of insulin and administer regular insulin in SQ doses (2-5 units) to maintain glucose between 80-120 mg/dL.
 - When active labor is achieved or if patient is NPO, initiate insulin therapy as follows:
 - Order 25 units regular insulin in 100 ml of NS
 - Using controlled infusion device, give this as “piggyback” to above I.V.
 - Administer as outlined below:

<u>Glucose</u>	<u>Rate</u>
<80	Insulin off
80 - 100	2 ml/hour = 0.5 u/hr

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101 - 140	4 ml/hour = 1.0 u/hr
141 - 180	6 ml/hour=1.5 u/hr
181 - 220	8 ml/hour=2.0 u/hr *
>220	10 ml/hour=2.5 u/hr *

*** Bolus 2-5 units when rate is increased**

- Measure blood glucose hourly and manage glucose as above.
 - Attempt to maintain blood sugar at 60 to 90 mg %
 - For patients undergoing cesarean section, monitor blood sugar every two hours while in L& D.
 - If patient delivers vaginally and is hemodynamically stable: d/c insulin drip in Labor and Delivery.
 - For cesarean section maintain the second IV line with Lactated Ringer's or saline without dextrose. Leave dextrose and insulin IV as previously ordered.
- Management should be individualized for patients on an insulin pump:
 - Glucose meter blood sugars should be monitored hourly.
 - If using a continuous sensor, blood sugar patterns can be assessed by up and down arrows. However, glucose meter blood sugars are necessary for calibration.
 - Pump Management (temporary basal rates)- **Management per MFM or Endocrine Team:**

<u>Glucose</u>	<u>Rate</u>
<60	Suspend pump
<80	50% basal rate
80-100	Usual basal rate
100-160	Give correction bolus and increase temporary basal rate to 150%
160-200	Give correction bolus and increase temporary basal rate to 200%
>200	Discontinue insulin pump and use IV insulin drip as above.

III. Post Delivery Diabetic Management

- A. The insulin requirement immediately decreases postpartum because of removal of the placenta.

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- Post Delivery Insulin Pump Management

Basal rates: Use pre-pregnancy basal rates or if unknown, decrease to 1/2 pregnancy rate settings

CHO:I ratio: Double the number

Sensitivity: Increase the number by 50% - Blood glucose target: 100-120

B. Gestational Diabetes

1. Diet-controlled - no insulin required during pregnancy (A1)

a. The patient should have the following test at 6-8 weeks in clinic.

- Fasting glucose plus 2-hr post 75g glucose tolerance test.
- Fasting lipid profile (if over 20 years of age)

b. If 2 hour values are abnormal, Diabetic Follow-up should be arranged with the primary provider. They will be responsible for maintaining long term control. For patients with no primary care provider, referral is made to internal medicine or family medicine at UIMC.

2. Insulin-required during pregnancy (A2)

- a. Most insulin-requiring gestational diabetics will not require treatment postpartum but should be checked with a random glucose on day 1 or 2.
- b. For random glucose <200 postpartum, follow-up is identical to non-insulin requiring gestational diabetes.
- c. For random glucose \geq 200 postpartum, the patient should be started on metformin, sent home on glucose monitoring and follow-up in clinic in 4-6 weeks at the postpartum visit with review of home glucose monitoring results.

3. Insulin Requiring Diabetes Mellitus (Class B-breast feeding or Class C-R regardless infant feeding choice)

- Uncomplicated vaginal or C/S delivery patients will resume normal diabetic diet.
- Extra calories are required for lactation (35 kcal/kg); generally between 2300 and 2700 kcal/day. Lactation is hampered by inadequate diets.
- Non-lactating mothers can be returned to their pre-pregnancy diabetic diet.

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Twice daily injections of intermediate and short acting insulin (see above for insulin pump):

- Typically begin at pre-pregnancy levels or if unknown, $\frac{1}{2}$ the amount required at delivery. [C/S may continue IV infusion or subcutaneous insulin until tolerating PO.]
- Glucose meter q 2-4 hrs

Serum glucose levels may be controlled by one of the following methods.

- Continue the I.V. insulin infusion as outlined in Diabetic Day of Delivery.
- Plasma glucose levels determined pre-prandial with coverage using regular insulin SQ

Follow-up weekly in clinic [review of home glucose monitoring] until euglycemia is achieved.

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3 Day Dietary Preparation

For 3 hour 100 gram Oral Glucose Tolerance Test

Getting Ready

- It is important that you eat at least three meals a day starting three days before the test. The meals should contain lots of starches (carbohydrate foods, such as bread, cereal, pasta, grains, rice, beans, starchy vegetables, potatoes, corn, peas, fruit and fruit juice, milk, yogurt, sweets...)
- Three days before the test, you must also eat/drink extra carbohydrate calories. Each day, eat 1 of the following in addition to your regular meals:

2 slices of bread
1 piece of cake
1 candy bar
1 can of non-diet soda
Other food equivalent to 30g carbohydrate

The Night Before Your Test

- After midnight the night before your scheduled test, do not eat or drink anything besides water.
- Do not smoke, chew gum or eat cough drops or candy. Do not take iron or vitamin pills.

The Test

- In the morning when you come to your appointment a blood sample will be taken (fasting blood glucose) and then you will be asked to drink a cold sweet drink (Glucola 100 g).
- Blood samples will then be taken at one hour, two hours, and three hours after you finish the sweet drink. During the test, you are not allowed to eat or drink anything except water.
- You may bring a snack to eat after the test is completed.

Please follow the instructions above carefully. It is very important not to “diet” before the test as dieting may cause false results.

DIABETIC SICK DAY MANAGEMENT

(INSULIN DEPENDENT)

Illness such as colds, flu, nausea or vomiting can be a problem, especially in persons taking insulin. At the onset of illness you should:

- **Continue to take your insulin.**
- Continue to monitor blood glucose level as directed by your doctor.
- Substitute liquids for solids if solids are not tolerated. For every 15 grams of carbohydrate from solids (breads, starches, cereals, fruit) use 15 grams of carbohydrate from liquids every 1-2 hours.
- Sip 8-12 ounces of fluid every hour or 4-6 ounces of fluid every 30 minutes.

Follow chart below:

FOOD AND BEVERAGE SUGGESTIONS FOR ILLNESS

Item	Measure	CHO/g	Kcal
Liquids			
Apple juice (unsweetened)	1/2 cup	15	58
Beef broth	1 cup	1	16
Cola drink	1/2 cup	14	53
Cranberry juice cocktail	1/2 cup	19	74
Eggnog	1/2 cup	17	171
Ginger ale	3/4 cup	15	62
Grape juice	1/3 cup	13	51
Instant Breakfast + skim milk	1/2 cup	17	101
Gatorade	1 cup	15	50
Skim milk	1 cup	12	90
Orange juice	1/2 cup	13	56
Tomato juice	1 1/2 cup	15	64
Semisolids			
Applesauce (unsweetened)	1/2 cup	14	53
Cream of wheat	1/2 cup	15	76
Cream of soup	1 cup	15	153
Custard	1/2 cup	15	153
Frozen juice bar	1	16	70
Honey	1 tbsp	16	64
Ice cream (vanilla)	1/2 cup	16	135
Gelatin (regular)	1/2 cup	16	80
Popsicle	1	10	40
Popsicle (sugar-free)	1	5	18
Pudding	1/2 cup	30	180
Pudding (sugar-free)	1/2 cup	16	103
Saltines	6	15	80
Graham crackers	3	16	80
Sherbet	1/4 cup	15	68
Sugar	1 tbsp	12	48
Yogurt (plain, low fat)	1 cup	12	120
Yogurt (fruited, low fat)	1/2 cup	20	112
Frozen yogurt	1/2 cup	16	118
Frozen yogurt (sugar-free)	1/2 cup	8	70

Ref: ADA Manual of Clinical Dietetics

**DIABETIC SICK DAY MANAGEMENT
(NONINSULIN DEPENDENT)**

Illness such as colds, flu, nausea or vomiting can be a problem when you are diabetic. At the onset of illness you should:

- Substitute liquids for solids if solids are not tolerated. For every 15 grams of carbohydrate from solids (breads, starches, cereals, fruit) use 15 grams of carbohydrate from liquids every 1-2 hours.
- Sip 8-12 ounces of fluid every hour or 4-6 ounces of fluid every 30 minutes.

Follow chart below:

FOOD AND BEVERAGE SUGGESTIONS FOR ILLNESS

Item	Measure	CHO/g	Kcal
Liquids			
Apple juice (unsweetened)	1/2 cup	15	58
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Cola drink	1/2 cup	14	53
Cranberry juice cocktail	1/2 cup	19	74
Eggnog	1/2 cup	17	171
Ginger ale	3/4 cup	15	62
Grape juice	1/3 cup	13	51
Instant Breakfast + skim milk	1/2 cup	17	101
Gatorade	1 cup	15	50
Skim milk	1 cup	12	90
Orange juice	1/2 cup	13	56
Tomato juice	1 1/2 cup	15	64
Semisolids			
Applesauce (unsweetened)	1/2 cup	14	53
Cream of wheat	1/2 cup	15	76
Cream of soup	1 cup	15	153
Custard	1/2 cup	15	153
Frozen juice bar	1	16	70
Honey	1 tbsp	16	64
Ice cream (vanilla)	1/2 cup	16	135
Gelatin (regular)	1/2 cup	16	80
Popsicle	1	10	40
Popsicle (sugar-free)	1	5	18
Pudding	1/2 cup	30	180
Pudding (sugar-free)	1/2 cup	16	103
Saltines	6	15	80
Graham crackers	3	16	80
Sherbet	1/4 cup	15	68
Sugar	1 tbsp	12	48
Yogurt (plain, low fat)	1 cup	12	120
Yogurt (fruited, low fat)	1/2 cup	20	112
Frozen yogurt	1/2 cup	16	118
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Ref: ADA Manual of Clinical Dietetics

MARS File Modules System Utilities User Utilities Change User Window Help

Pregnancy Assessment

345 1 Zzcathy Istesting 09/08/1971 00/00/0000 preg Allergies Unknown
 Meds Unknown
 Age 34yrs Hgt prepreg BWV G/TPAL 1/0000 Clinical Guidelines ?Blood Status? Problems Unknown

#	Date	Encounter Code	Wt (lbs)	Δ	SBP/DBP	GA (w.d)	FH	FM	Edema	UC	Bleeding	Vag Dis	Return	CARE SITE	More Providers	
															Providers	Attending
1	01/18/2006	DAT												L&D		driscoll
3	01/19/2006	IPA												FCID		driscoll
4	01/19/2006	HX												FCID		driscoll
5	01/19/2006	CLN												FCID		driscoll

While focused on the current CLN encounter, mouse click the 'No Diabetes' button. You will be asked to confirm that you want to begin a Diabetes flowsheet.

Fetal Information (for current maternal encounter)

Fetus ID	FHR	EFW	Presentation	NST	AFI	BPP (x of 8)	CST
a							

Summary New Fetus

No PCP or Referring Provider ?
 No NBN Provider
 Defaulter: C Driscoll / LD ?

No Diabetes
 Signoff
 Exit

Delete Record
 Filter Records

Add New Encounter Clinical (CLN) Patient Education Reports

user: driscoll started: 1/25/06 08:12

MARS File Modules System Utilities User Utilities Change User Window Help

Diabetes Details

#	Date	Data Type	Insulin Rx			Blood Glucose			Comment
			AM Insulin NPH	PM Insulin NPH	PM Insulin Reg	Post-breakfast	Post-lunch	Post-dinner	
1	01/25/2006	L							
2	01/25/2006	H							

Once you open the Diabetic Flowsheet you mouse click 'Insert Diabetes Records' - a box will open -you will be given a choice:

- High/Low (as seen above)
- 'Detailed Records' for each day in a given timeframe

Make selection and add data as desired. The DM 'Type' needs to be entered only once and will copy to all future records. The 'No Diabetes' button will change to RED '**Diabetes**' at UPDATE

Fetal Information (for current maternal encounter)

Fetus ID	FHR	EFW	Presentation	NST	AFI	BPP (x of 8)	CST
a							

?

 ?

user: driscoll started: 1/25/06 08:12