GBMC
6701 N. Charles Street
Baltimore MD 21204

Insulin Pump Pre-Surgery Recommendations

SURGEON OFFICE STAFF: Please fill out below section

PATIENT'S NAME: _____ DATE OF BIRTH: _____/_____/_____
MRN: _____ CSN: _____
TODAY'S DATE: _____/_____/_____

PROCEDURE: _____
DATE OF SURGERY: _____/_____/_____ LOCATION (GOR, Sherwood, etc.): _____
ANTICIPATED LENGTH OF SURGERY (hours): _____ ☐ Inpatient ☐ Outpatient

To ensure the safety of all of our surgical patients this form must be completed no later than 72 hours prior to surgery. Your insulin recommendations will enable the anesthesiologist and surgeon to provide the most comprehensive plan of care for your patient and improve glucose management during and after the procedure.

ENDOCRINOLOGIST or PCP: Please fill out below section

INSTRUCTIONS:

1. In compliance with GBMC's insulin pump policy, this form must be completed and faxed by the physician managing the patient's insulin pump to the Presurgical testing Center: 443-849-3013
2. Please complete this form no earlier than 30 days prior to and no later than 72 hrs prior to the surgery/procedure.
3. Your patient must provide their own insulin and bring additional pump supplies for their procedure/hospitalization.

INSULIN PUMP:

1. Device manufacturer and model of pump: _____
2. Insulin to be used in pump: _____
3. Basal Rates:
   Between hours of ____-_____, units per hour _____
   Between hours of ____-_____, units per hour _____
   Between hours of ____-_____, units per hour _____
   Between hours of ____-_____, units per hour _____
4. Insulin to Carbohydrate Ratio:
   Between hours of ____-_____, __unit per __grams of carbohydrate
   Between hours of ____-_____, __unit per __grams of carbohydrate
5. Insulin sensitivity: 1 unit of insulin decreases glucose by _____mg/dl
6. Target Glucose levels: _____
7. IF PUMP RATES ARE TO BE MODIFIED PRIOR TO SURGERY, I HAVE RECOMMENDED THE FOLLOWING
   _____
8.

INSULIN RECOMMENDATIONS

IF PUMP NEEDS TO BE DISCONTINUED I RECOMMEND:

1) Basal coverage with ____units of Levemir to be given 60 minutes prior to discontinuing pump
2) Correction sliding scale Novolog: __low dose __medium dose __high dose __very high dose
3) Novolog meal coverage when appropriate: _____

Physician completing form (PRINT): _____ Contact Phone Number: _____
Physician Signature: _____ Date_____ Time: _____