Sliding Scale Insulin

SLIDING SCALE INSULIN

There are no right or wrong answers. Mark the response that best describes you over the period stated, and answer every item.

Name: _____ **Date completed:** _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy **Record / MRN number:** _____

Answer each of the 10 items below. Choose the response that best describes the last two weeks unless you are told otherwise.

1. I understand what sliding insulin involves and why it has been recommended.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

2. I am confident managing readings, timings and trend direction day to day.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

3. Dose adjustments and titration decisions has been discussed with me.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

4. I know who to contact if something changes between appointments.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

5. I am able to follow the advice I have been given about hypo- and hyperglycemic episodes.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

6. I have enough information to make decisions about my care.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

7. The symptoms I came in with have affected my daily activities.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

8. I have found it difficult to keep up with review intervals and complication screening.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

9. I have had support from family, friends or carers with this.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

10. I am satisfied with the care I have received so far.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

Anything else you would like the team to know

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Total score: _____ **Interpretation:** _____

Completed by: _____ **Reviewed by / date:** _____