



## Subcutaneous Insulin Correction Standard Orders

*These orders are to be used as a guideline and do not replace sound clinical judgement and professional practice standards.  
Patient allergy and contraindications must be considered when completing these orders.*

- Automatically activated (If not in agreement with an order cross out and initial).
  Requires a check(√) for activation

**Allergies:**  Unknown  No  Yes (describe) \_\_\_\_\_

**To be used in conjunction with long acting insulin while titrating the long-acting insulin dose and not as a stand alone treatment**

**Monitoring:** Blood Glucose Meter:

- TID ac  TID ac + QHS  Other: \_\_\_\_\_  
 Q4h (continuous enteral feeds & TPN)  Q6h (continuous enteral feeds & TPN)

**Correction Insulin (Select One):**

- Insulin Lispro (Humalog®) OR  Insulin Regular (Humulin R)

**Correction Insulin Administration Frequency:**

- Before each meal  
 Q4h (if using Lispro for patients receiving continuous enteral feeds/TPN)  
 Q6h (if using Humulin R for patients receiving continuous enteral feeds/TPN)  
 Other: \_\_\_\_\_

**Correctional subcutaneous insulin at bedtime is generally not recommended**

**Subcutaneous Insulin Correction Dosing (Select one):**

Blood Glucose mmol/L Select One	<input type="checkbox"/> Low Dose If TDI (Total Dose Insulin) less than 60 units	<input type="checkbox"/> Moderate Dose If TDI 60 – 100 units	<input type="checkbox"/> High Dose If TDI more than 100 units	<input type="checkbox"/> Custom Dose
Less than 4 mmol/L	Follow Emergency Management of Hypoglycemia (Adult/Pediatric) CLI.6010.SG.007			
4.1 – 9.9	0 units	0 units	0 units	0 units
10 – 14	2 units	3 units	6 units	_____ units
14.1 – 18	3 units	4 units	8 units	_____ units
18.1 – 22	4 units	5 units	10 units	_____ units
Greater than 22 mmol/L	Call Prescriber			

**Notify prescriber if:**

- Patient becomes NPO
- Oral diet initiated from NPO status
- Oral diet advances from fluids to solids
- TPN or Enteral feeds held/rate changed/stopped due to change in condition or diagnostics

**\*\*\*Standard Orders should be Reassessed every 48 hours by Prescriber\*\*\***

PRESCRIBER'S SIGNATURE: \_\_\_\_\_ PRINTED NAME: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Order Transcribed

FAX/SCAN TO PHARMACY

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Init: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Init: \_\_\_\_\_