T h e r a p i e p l a n zur Insulindosisanpassung

Patient:

Arzt:

Telefon:

Fax:

Insulinname	BZ-Wert	morgens	mittags	abends	nachts	Spritz-Ess-Abstand Minuten
		IE	IE	IE	IE	
		IE	IE	IE	IE	
		IE	IE	IE	IE	
		IE	IE	IE	IE	
		IE	IE	IE	IE	
		IE	IE	IE	IE	
		IE	IE	IE	IE	
		IE	IE	IE	IE	
		IE	IE	IE	IE	
Basisinsulin Name:	**feste Dosis**				**IE**	
	BE-Verteilung					

Diabeteskommission
AOK Rheinland-Pfalz
Stand: 08.06.2004