MY DIABETES ACTION PLAN

Date: _____

Review this action plan with your doctor and have your doctor fill in the blanks and sign and date the plan. Have your doctor review this action plan each year or more often if needed.

Patient Name: _____ DOB: _____ CIN#: _____

Provider Name: _____ Provider ID#: _____

Green Zone: "I'm doing well and my blood sugar is under control."

- My HbA1c is under _____. **My Goal HbA1c: _____**
- My average blood sugar is under 150.
- Most of my fasting blood sugars are under 140.

Plan of Action: _____
_____
_____

Yellow Zone: "My blood sugar may be a sign that I need to make some changes."

- My HbA1c is between _____ and _____.
- My average blood sugar is between 150-210.
- Most of my fasting blood sugars are under 180.

Plan of Action: _____
_____
_____

Red Zone: "I feel I am in danger and have one or more of the symptoms below."

- My HbA1c is greater than _____.
- My average blood sugar is over 210.
- Most of my fasting blood sugars are well over 180.

Plan of Action: _____
_____
_____

Physician Guideline: If patient is often in the red zone, consider insulin therapy or referral to endocrinologist.