**

**Enrolled Subject Bedside Sheet**

***FOR ALL QUESTIONS AND CONCERNS, contact (INSERT LOCAL PAGER HERE)***

**Subject’s Bedspace: \_\_\_\_\_\_\_\_**

**Subject’s MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subject’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)**

**Study ID: \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ - \_\_**

**Randomization Password: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Nursing Responsibilities:*

* Please check glucose level every four hours (or per unit protocol)
* If subject has result > 150 mg/dL, recheck as soon as possible
  + - Both results >150 mg/dL must be within 24 hours
* If next sample is also > 150 mg/dL, subject qualifies for Randomization

(samples must be *consecutive*)

* + Please see Randomization Procedure Checklist
* Initial glucose > 150 mg/dL: Date: \_\_\_/\_\_\_/\_\_\_\_\_\_ Time \_\_\_\_\_:\_\_\_\_\_
* Confirmatory glucose > 150 mg/dL: Date: \_\_\_/\_\_\_/\_\_\_\_\_\_ Time \_\_\_\_\_:\_\_\_\_\_