MTA/New York City Transit
Human Resources – Occupational Health Services
DIABETES MONITORING REPORT

NAME: ______________________ ______________________ ______
Last name First Name M.I.

SS# ______________________ PASS # ______________________

The following is to be completed by the treating physician: Please print or type.

1. All Diagnoses/Status ______________________

2. Name and Dosage of all medications ______________________

2.a Insulin YES ☐ NO ☐

3.a Has Diabetes been under good control? YES ☐ NO ☐
IF NO EXPLAIN: ______________________

3.b Any episodes of hypoglycemia and or symptoms? YES ☐ NO ☐
IF YES EXPLAIN: ______________________

3.c Any altered states of consciousness? YES ☐ NO ☐
IF YES EXPLAIN: ______________________

5. Any evidence of :

4.a Diabetic Retinopathy YES ☐ NO ☐
IF YES EXPLAIN: ______________________

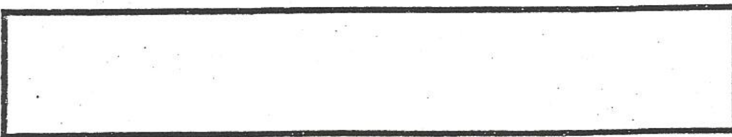
4.b Diabetic Nephropathy YES ☐ NO ☐
IF YES EXPLAIN: ______________________

4.c Diabetic Neuropathy YES ☐ NO ☐
IF YES EXPLAIN: ______________________

5. Please provide copies of ALL Lab Reports for the last 6 Months, including 1) FBS and 2) glycosylated hemoglobin.

DATE: ________ ________ ________
MONTH DAY YEAR

Doctors Stamp



Doctors Signature: ______________________

Date: ______________________ Due Date ______________________ Initial ______________________