

**Nursing Process Focus:
Patients Receiving Levothyroxine (Synthroid)**

<p>Assessment Prior to administration:</p> <ul style="list-style-type: none"> • Obtain complete health history including allergies, drug history and possible drug interactions. • Assess for presence/history of hypothyroidism, myxedema coma, thyrotoxicosis, cardiovascular disease. • Obtain vital signs and EKG • Assess thyroid function 	<p>Potential Nursing Diagnoses</p> <ul style="list-style-type: none"> • Tissue perfusion, Risk for Ineffective related to tachycardia secondary to adverse effects of drug therapy • Sleep pattern, Risk for Disturbed related to adverse effects of drug therapy • Nutrition, Risk for Imbalance: less than body requirements related to weight loss secondary to adverse effects of drug therapy • Pain related to headache secondary to drug therapy • Noncompliance, Risk for related to long term drug therapy
<p>Planning: Patient Goals and Expected Outcomes</p> <p>The patient will:</p> <ul style="list-style-type: none"> • Remain free of drug side effects including chest pains, palpitations, insomnia, tremors, nervousness, edema and diarrhea. • Demonstrate understanding of the life long need for drug therapy. • Demonstrate ability to sleep at least six hours nightly • Maintain body weight at expected level. • Maintain effective tissue perfusion 	
<p>Implementation</p>	
<p>Interventions and (Rationales)</p>	<p>Patient Education/Discharge Planning</p>
<ul style="list-style-type: none"> • Monitor cardiovascular function including vital signs, especially in elderly patients. (Medication may cause cardiovascular collapse in undiagnosed cardiovascular disease because the levothyroxine increases the basal metabolic rate thereby increasing heart rate). 	<p>Instruct patient to:</p> <ul style="list-style-type: none"> • Take own pulse before taking medication • Withhold medication and notify health care provider if pulse is greater than 100
<ul style="list-style-type: none"> • Monitor renal function. (An increased metabolic rate may increase the work load of the kidney which may not be tolerated in a patient with impaired kidney function.) 	<p>Advise patient to:</p> <ul style="list-style-type: none"> • Notify health care provider of any weight gain. • Monitor blood pressure and notify health care provider of significant changes.
<ul style="list-style-type: none"> • Monitor adrenal function. (Patients with diabetes mellitus, diabetes insipidus and Addison's disease may see a worsening of symptoms because of the initial increase in basal metabolism.) 	<p>Advise patients:</p> <ul style="list-style-type: none"> • That the worsening of symptoms are only temporary. • To notify health care provider if symptoms become greater than the patient is able to handle at home.

<ul style="list-style-type: none"> • Monitor blood sugar in patients with diabetes mellitus. (The dose of insulin or oral hypoglycemics may need to be adjusted as basal metabolism is increased.) 	<ul style="list-style-type: none"> • Advise diabetic patients to increase self monitoring of blood glucose.
<ul style="list-style-type: none"> • Monitor weight. (Decreased weight is an indicator that the medication is effective.) 	<ul style="list-style-type: none"> • Advise patient to weigh self every week.
<ul style="list-style-type: none"> • Periodically monitor thyroid function. 	<p>Advise patient:</p> <ul style="list-style-type: none"> • That the use of this medication will continue for life • Not to change brand of medication • To keep all laboratory appointments
<p style="text-align: center;">Evaluation of Outcome Criteria</p> <p>Evaluate the effectiveness of drug therapy by confirming that patient goals and expected outcomes have been met (see “Planning”).</p>	

Nursing Process Focus:
Patients Receiving Propylthiouracil (PTU)

<p>Assessment</p> <p>Prior to administration:</p> <ul style="list-style-type: none"> • Obtain complete health history including allergies, drug history and possible drug interactions. • Assess for presence/history of hyperthyroidism, iodine induced thyrotoxicosis, toxic nodular goiter, bone marrow depression • Obtain vital signs and EKG 	<p>Potential Nursing Diagnoses</p> <ul style="list-style-type: none"> • Injury, Risk for (vertigo) related to adverse effects of drug therapy • Infection, Risk for related to myelosuppression • Nutrition, Risk for Imbalanced : less than body requirements related to ineffective response to drug therapy • Constipation, Risk for related to decreased motility secondary to response to medication
<p>Planning: Patient Goals and Expected Outcomes</p>	
<p>The patient will:</p> <ul style="list-style-type: none"> • Remain free of side effects including sore throat, fever, tinnitus, bradycardia, vertigo, bruising and bleeding. • Demonstrate understanding of need for frequent monitoring of thyroid function. • Remain free of signs of infection • Maintain weight at expected level 	
<p>Implementation</p>	
<p>Interventions and (Rationales)</p>	<p>Patient Education/Discharge Planning</p>
<ul style="list-style-type: none"> • Monitor liver function including signs of jaundice. (This medication may cause temporary elevations in liver transaminase levels. Hepatitis may occur.) 	<ul style="list-style-type: none"> • Instruct patient to report changes in skin color, or sclera to the health care provider.
<ul style="list-style-type: none"> • Monitor white blood cell count periodically because this medication may cause agranulocytosis. 	<ul style="list-style-type: none"> • Instruct patient to immediately report signs of infection to the health care provider.
<ul style="list-style-type: none"> • Monitor vital signs. (Thyroid function begins to return to a more normal level, blood pressure, pulse and temperature will be good indicators of the medication's effectiveness.) 	<p>Instruct patient:</p> <ul style="list-style-type: none"> • In skill of taking own pulse. • To take pulse every day and report any pulse less than 60.
<ul style="list-style-type: none"> • Monitor weight. (The patient should gain weight as thyroid function begins to decrease.) 	<ul style="list-style-type: none"> • Instruct patient in signs and symptoms of hypothyroidism (significant weight gain, lethargy, constipation, mental confusion).
<ul style="list-style-type: none"> • Monitor intake and output including signs of edema (which would indicate that the medication is not being effective). 	<ul style="list-style-type: none"> • Instruct patient to report any edema.

<ul style="list-style-type: none"> • Monitor mental status: mental depression (This would indicate a lack of effectiveness of the medication.) 	<ul style="list-style-type: none"> • Instruct patient to report feeling of depression to the health care provider.
<ul style="list-style-type: none"> • Monitor thyroid hormone and complete blood count periodically for response to medication. 	<ul style="list-style-type: none"> • Instruct patient to keep all laboratory appointments.
<ul style="list-style-type: none"> • Protect patient from any injury caused by drowsiness or vertigo. 	<ul style="list-style-type: none"> • Advise patient to avoid driving or operating dangerous equipment until effects of drug is known.

Evaluation of Outcome Criteria

Evaluate the effectiveness of drug therapy by confirming that patient goals and expected outcomes have been met (see “Planning”).

Nursing Process Focus:
Patients Receiving Hydrocortisone (Aeroseb-HC, Alphaderm, Cetacort, others)

<p>Assessment</p> <p>Prior to administration:</p> <ul style="list-style-type: none"> • Obtain complete health history including allergies, drug history and possible drug interactions. • Assess for presence/history of adrenocortical insufficiency, hypercalcemia, inflammation, immunosuppression. • Obtain weight • Assess complete blood count and electrolytes 	<p>Potential Nursing Diagnoses</p> <ul style="list-style-type: none"> • Infection, Risk for related to immunosuppression • Injury, Risk for (fracture) related to osteoporosis secondary to adverse effects of drug therapy • Cardiac output, Risk for Decreased related to circulatory collapse secondary to abrupt discontinuation of drug therapy • Nutrition, Risk for Imbalanced: more than body requirements related to adverse effects of drug therapy • Fluid volume, Risk for imbalance: excess related to fluid retention secondary to adverse effects of medication
<p>Planning: Patient Goals and Expected Outcomes</p>	
<p>The patient will:</p> <ul style="list-style-type: none"> • Remain free of symptoms of infection • Remain free of physical injury • Demonstrate compliance with treatment regimen • Maintain body weight within expected range 	
<p>Implementation</p>	
<p>Interventions and (Rationales)</p>	<p>Patient Education/Discharge Planning</p>
<ul style="list-style-type: none"> • Monitor renal function. (Medication is contraindicated in patients with acute glomerulonephrosis because this medication increases glomerular filtration rate.) 	<ul style="list-style-type: none"> • Instruct patient to report changes in weight and blood pressure.
<ul style="list-style-type: none"> • Monitor liver function. (Medication promotes hepatic gluconeogenesis. Use with caution in patients with cirrhosis and Hepatitis B.) 	<ul style="list-style-type: none"> • Instruct patient to notify health care provider of any jaundice, pale stools, dark urine, or abdominal pain.
<ul style="list-style-type: none"> • Evaluate thyroid function. (Normal thyroid function is necessary to prevent increased hepatic metabolism.) 	<ul style="list-style-type: none"> • Instruct patient to notify the health care provider of any signs of hyper or hypothyroidism such as irritability or extreme fatigue, weight loss or gain, or constipation or diarrhea.
<ul style="list-style-type: none"> • Monitor blood glucose. (Hydrocortisone causes increased gluconeogenesis and decreased glucose use.) 	<p>Advise diabetic patient to:</p> <ul style="list-style-type: none"> • Closely monitor blood glucose because insulin needs may increase while on this medication • Keep all laboratory appointments

<ul style="list-style-type: none"> • Monitor for GI conditions, including evidence of GI bleeding. (Medication increases risk of peptic ulcer.) 	<p>Advise patient to:</p> <ul style="list-style-type: none"> • Abstain from alcohol and avoid cigarettes while on this medication because both may increase the chance of the development of peptic ulcers. • Immediately report sign of GI bleeding to health care provider • Recognize signs and symptoms of peptic ulcers, and to report immediately • Report any blood in stool immediately
<ul style="list-style-type: none"> • Monitor for infection. (Medication may mask signs and symptoms of infection because one of the actions of hydrocortisone is to suppress phagocytosis and decrease the number of circulating neutrophils and lymphocytes.) 	<ul style="list-style-type: none"> • Advise patient that normal signs and symptoms of infection may not be present and to report all vague symptoms to the health care provider
<ul style="list-style-type: none"> • Monitor for proper use of medication. (Circulatory collapse may occur if the medication is discontinued abruptly due to acute adrenal insufficiency which can develop with long term use of hydrocortisone.) 	<ul style="list-style-type: none"> • Instruct patient not to stop medication abruptly.
<ul style="list-style-type: none"> • Monitor weight. (Hydrocortisone may cause increased appetite and the glucocorticoid effect on carbohydrate, fat, and protein metabolism.) 	<ul style="list-style-type: none"> • Advise patient that a slight weight gain is normal at the beginning of therapy but patient should report additional weight gain to the health care provider.
<ul style="list-style-type: none"> • Be alert for blood vessel fragility, especially during venipunctures. 	<ul style="list-style-type: none"> • Advise patient to use caution and protect skin while on this medication.
<ul style="list-style-type: none"> • Protect patient from injuries especially falls due to the possibility of spontaneous fracture. (New bone formation is reduced and bone reabsorption is enhanced with hydrocortisone. It also interferes with the intestinal absorption of calcium.) 	<p>Advise patient to:</p> <ul style="list-style-type: none"> • Carry medication identification with name of medication • Check with the health care provider about taking a calcium supplement while on hydrocortisone therapy.
<p style="text-align: center;">Evaluation of Outcome Criteria</p> <p>Evaluate the effectiveness of drug therapy by confirming that patient goals and expected outcomes have been met.(see “Planning”).</p>	

NURSING PROCESS FOCUS**PATIENTS RECEIVING EPOETIN ALFA**

ASSESSMENT	POTENTIAL NURSING DIAGNOSES
<p>Prior to administration:</p> <ul style="list-style-type: none">• Obtain complete health history including allergies, drug history, and possible drug reactions.• Assess reason for drug administration such as presence/history of anemia secondary to chronic renal failure, malignancy, chemotherapy, autologous blood donation, and HIV-infected patients treated with zidovudine.• Assess vital signs, especially blood pressure.• Assess complete blood count, specifically hematocrit and hemoglobin levels, to establish baseline values.	<ul style="list-style-type: none">• Ineffective Tissue Perfusion, related to ineffective response to drug• Risk for Injury (weakness, dizziness, syncope), related to anemia• Risk for Injury, related to seizure activity secondary to drug• Activity Intolerance, related to RBC deficiency• Deficient Knowledge, related to drug therapy
PLANNING: PATIENT GOALS AND EXPECTED OUTCOMES	
<p>The patient will:</p> <ul style="list-style-type: none">■ Exhibit an increase in hematocrit level and improvement in anemia-related symptoms■ Immediately report effects such as severe headache, chest pain, confusion, numbness, or loss of movement in an extremity■ Demonstrate an understanding of the drug's action by accurately describing drug side effects and precautions	

IMPLEMENTATION

Interventions and (Rationales)	Patient Education/Discharge Planning
<ul style="list-style-type: none"> ■ Monitor vital signs, especially blood pressure. (The rate of hypertension is directly related to the rate of rise of the hematocrit. Patients who have existing hypertension are at higher risk for stroke and seizures. Hypertension is also much more likely in patients with chronic renal failure.) 	<p>Instruct patient:</p> <ul style="list-style-type: none"> ■ In the importance of periodic blood pressure monitoring and on the proper use of home blood pressure monitoring equipment ■ Of “reportable” blood pressure ranges (“Call healthcare provider when blood pressure is greater than...”)
<ul style="list-style-type: none"> ■ Monitor for side effects, especially symptoms of neurologic or cardiovascular events. 	<ul style="list-style-type: none"> ■ Instruct patient to report side effects such as nausea, vomiting, constipation, redness/pain at injection site, confusion, numbness, chest pain, and difficulty breathing.
<ul style="list-style-type: none"> ■ Monitor patient’s ability to self-administer medication. 	<p>Instruct patient:</p> <ul style="list-style-type: none"> ■ In the technique for SC injection if patient is to self-administer the medication ■ On proper disposal of needles and syringes
<ul style="list-style-type: none"> ■ Monitor laboratory values such as hematocrit and hemoglobin to evaluate effectiveness of treatment. (Increases in hematocrit and hemoglobin values indicate increased RBC production.) 	<p>Instruct patient:</p> <ul style="list-style-type: none"> ■ On the need for initial and continuing laboratory blood monitoring ■ To keep all laboratory appointments ■ Of latest hematocrit value so that physical activities may be adjusted accordingly

<ul style="list-style-type: none"> ■ Monitor patient for signs of seizure activity. (Seizures result in a rapid rise in the hematocrit—especially during first 90 days of treatment.) 	<ul style="list-style-type: none"> ■ Instruct patient to not drive or perform hazardous activities until the effects of the drug are known.
<ul style="list-style-type: none"> ■ Monitor patient for signs of thrombus such as swelling, warmth, and pain in an extremity. (As hematocrit rises, there is an increased chance of thrombus formation particularly for patients with chronic renal failure.) Report immediately. 	<p>Instruct patient:</p> <ul style="list-style-type: none"> ■ To report any increase in size, pain, and/or warmth in an extremity ■ On signs and symptoms of blood clots ■ Not to rub or massage calves and to report leg discomfort
<ul style="list-style-type: none"> ■ Monitor dietary intake. Ensure adequate intake of all essential nutrients. (Response to this medication is minimal if blood levels of iron, folic acid, and vitamin B₁₂ are deficient.) 	<p>Instruct patient to:</p> <ul style="list-style-type: none"> ■ Maintain adequate dietary intake of essential vitamins and nutrients ■ Continue to follow necessary dietary restrictions if receiving renal dialysis
<p>EVALUATION OF OUTCOME CRITERIA</p>	
<p>Evaluate the effectiveness of drug therapy by confirming that patient goals and expected outcomes have been met (see “Planning”).</p>	

**Nursing Process Focus:
Patients Receiving Regular Insulin (Humulin, Novolin)**

<p>Assessment</p> <p>Prior to administration:</p> <ul style="list-style-type: none">• Assess any patient allergies. Older forms of insulin are made from beef and pork and may cause allergic reactions in sensitive patients.• Assess vital signs.• Assess blood glucose level• Assess appetite and presence of any symptoms that indicate the patient will not be able to consume or retain next meal.• Assess subcutaneous areas for lipodystrophies and other areas which are possible insulin injection sites.• Assess patient's knowledge of insulin and insulin administration.• Assess potassium level	<p>Potential Nursing Diagnoses</p> <ul style="list-style-type: none">• Injury, Risk for (hypoglycemia) related to adverse effects of drug therapy• Knowledge deficient related to need for self injection• Nutrition, Risk for Imbalanced related to adverse effects of drug therapy• Knowledge Deficient, related to management of disease process
<p>Planning: Patient Goals & Expected Outcomes</p> <p>The patient will:</p> <ul style="list-style-type: none">• Demonstrate knowledge of symptoms of complication of drug therapy including irritability, dizziness, diaphoresis, hunger, behavior changes and changes in level of consciousness.• Demonstrate ability to self administer insulin.• Demonstrate understanding of lifestyle modifications necessary for successful maintenance of drug therapy	

Implementation	
Interventions and (Rationales)	Patient Education/Discharge Planning
<ul style="list-style-type: none"> • Monitor patient's ability to self administer insulin. (To evaluate safe administration of drug.) 	Instruct patient and caregivers: <ul style="list-style-type: none"> • How to do blood glucose testing and to monitor blood glucose before each meal and before insulin administration. • Use only an insulin syringe, calibrated the same as the strength of the insulin, to administer insulin • How to draw the clear regular insulin into the syringe first if mixing with cloudy insulin such as NPH. • To rotate insulin sites and to develop a rotational plan. • To be careful to use only the type of insulin prescribed by the health care provider, and to carefully check the bottle to insure patient is using the correct insulin.
<ul style="list-style-type: none"> • Increase blood glucose monitoring if patient is experiencing fever, nausea, vomiting, or diarrhea. (Illness may increase insulin need.) 	<ul style="list-style-type: none"> • Instruct patient to increase blood glucose monitoring when experiencing fever, nausea, vomiting or diarrhea, as illness usually requires adjustments in insulin doses.
<ul style="list-style-type: none"> • Check urine for ketones if blood glucose is over 300. (Ketones will spill into the urine at this glucose level and provide an early sign of impending diabetic ketoacidosis.) 	Teach patient: <ul style="list-style-type: none"> • How to check urine for ketones. • That the presence of ketones may be an early sign of impending diabetic ketoacidosis. • Unlike hypoglycemia reactions, which develop quickly, ketoacidosis normally develops slowly but is still a serious problem that needs to be corrected.
<ul style="list-style-type: none"> • Monitor patient's weight on a routine basis and report any significant changes in weight to health care provider. (Weight gain or loss may alter insulin need.) 	<ul style="list-style-type: none"> • Teach patient that changes in weight will alter insulin needs to weigh self on a routine basis and to report significant changes e.g. plus or minus ten pounds to health care provider.

<ul style="list-style-type: none"> • Monitor blood pressure and pulse. (Increased pulse and blood pressure are early signs of hypoglycemia or renal dysfunction.) 	<p>Teach patient and caregivers to:</p> <ul style="list-style-type: none"> • Take the patient's blood pressure and pulse • Report significant changes to the healthcare provider
<ul style="list-style-type: none"> • Monitor potassium level. (Insulin causes potassium to move into the cell; therefore the patient may become hypokalemic if not monitored.) 	<ul style="list-style-type: none"> • Instruct patient to notify the health care provider at the first sign of heart irregularity.
<ul style="list-style-type: none"> • Check blood glucose and feed patient some form of simple sugar at the first sign of hypoglycemia. Follow 15/15 rule: patient needs approximately 15 grams of a simple sugar, which is about 1/2 cup of fruit juice or cola or three teaspoons of sugar, or five lifesaver candies. When in hypoglycemia, give 15 grams of simple sugar, wait 15 minutes, and if no better then give 15 more grams. (It is important to raise blood sugar immediately with a simple sugar.) 	<ul style="list-style-type: none"> • Teach patient that exercise may increase insulin needs therefore blood glucose should be checked before and after exercise and to keep a simple sugar on their person while exercising.
<ul style="list-style-type: none"> • Administer regular insulin approximately 30 minutes before meals. (Insulin will be absorbed and available when the patient begins to eat.) 	<ul style="list-style-type: none"> • Advise patient to check blood glucose and administer regular insulin only when food is available to eat.
<p style="text-align: center;">Evaluation of Outcome Criteria</p> <p>Evaluate the effectiveness of drug therapy by confirming that patient goals and expected outcomes have been met (see “Planning”).</p>	

**Nursing Process Focus:
Patients Receiving Glipizide (Glucotrol, Glucotrol XL)**

<p>Assessment Prior to administration:</p> <ul style="list-style-type: none"> • Obtain complete health history including allergies, drug history and possible drug interactions • Assess for allergies • Assess location and level of pain • Assess knowledge of medication • Assess for history of Type 2 diabetes mellitus 	<p>Potential Nursing Diagnoses</p> <ul style="list-style-type: none"> • Injury, Risk for (hypoglycemia) related to adverse effects of drug therapy • Fluid Volume, Risk for Imbalance: deficit related to fluid loss secondary to diarrhea • Pain (abdominal) related to adverse effects of medication • Knowledge deficient related to new drug regimen
<p>Planning: Patient Goals & Expected Outcomes The patient will:</p> <ul style="list-style-type: none"> • Demonstrate understanding of signs and symptoms that need to be reported immediately including: nausea, diarrhea, jaundice, rash, headache, anorexia, abdominal pain, tachycardia, seizures and confusion. • Demonstrate ability to accurately self-monitor blood glucose. • Demonstrate blood glucose within a normal range. 	
<p>Implementation</p>	
<p>Interventions and (Rationales)</p>	<p>Patient Education/Discharge Planning</p>
<ul style="list-style-type: none"> • Monitor blood glucose at least daily and urinary ketones if blood glucose over 300. 	<p>Teach patient:</p> <ul style="list-style-type: none"> • how to test urine for ketones, • how to test blood glucose
<ul style="list-style-type: none"> • Monitor intake and output and monitor for signs and symptoms of any urinary problems. 	<ul style="list-style-type: none"> • Instruct patient to notify the health care provider at the first signs of urinary difficulties.
<ul style="list-style-type: none"> • Review lab work for any abnormalities in liver function. (Drug is metabolized in the liver and may cause elevations in AST and LDH.) 	<ul style="list-style-type: none"> • Instruct patient to notify the health care provider at the first sign of yellowed skin, pale stools, or dark urine.
<ul style="list-style-type: none"> • Obtain as accurate a history of alcohol use as possible. (Excessive alcohol intake places patient at risk for elevation of lactic acid and disulfiram-like reaction.) 	<ul style="list-style-type: none"> • Advise patient to abstain from alcohol and to avoid liquid over the counter medications, which may contain alcohol while taking this medication.
<ul style="list-style-type: none"> • Monitor for any signs and symptoms of illness or infection. (Illness may change the medication need.) 	<ul style="list-style-type: none"> • Instruct patient to notify the health care provider at the first sign of fatigue, muscle weakness and nausea.
<ul style="list-style-type: none"> • Monitor for signs of hypoglycemia, especially in the elderly. (Elderly patients are much more prone to hypoglycemia because many have decreased renal and hepatic function.) 	<p>Teach patient and caregivers:</p> <ul style="list-style-type: none"> • The signs and symptoms of hypoglycemia (hunger, irritability, sweating) • At first sign of hypoglycemia check

	<p>blood glucose and eat a simple sugar. If symptoms do not improve call 911.</p> <ul style="list-style-type: none"> • To monitor blood glucose before breakfast and supper • Not to skip meals and to follow diet specified by health care provider
<ul style="list-style-type: none"> • Monitor weight, weighing at the same time of day each time. (Changes in weight will impact the amount of medication needed to control blood glucose.) 	<ul style="list-style-type: none"> • Advise patient to weigh each week, at the same time of day, and report any significant loss or gain to primary health care provider.
<ul style="list-style-type: none"> • Monitor vital signs. (Increased pulse and blood pressure are early signs of hypoglycemia.) 	<ul style="list-style-type: none"> • Teach patient and caregiver how to take accurate blood pressure and to check temperature and count the pulse.
<ul style="list-style-type: none"> • Observe for skin rashes or itching and notify the health care provider at the first sign. (These are signs of an allergic reaction to the medication.) 	<ul style="list-style-type: none"> • Advise patient and caregivers of the importance of notifying health care provider of skin rashes and itching.
<ul style="list-style-type: none"> • Monitor activity level (to provide more effective management of disease process). 	<p>Advise patient to:</p> <ul style="list-style-type: none"> • Increase exercise which will help lower blood sugar • Closely monitor blood glucose when involved in vigorous physical activity
<ul style="list-style-type: none"> • Use cautiously in patients who are older adults, patients with impaired renal and hepatic function, and malnourished patients. (Medication is absorbed from the GI tract and metabolized in the liver.) 	<ul style="list-style-type: none"> • Instruct patient to monitor blood glucose closely and report consistent high or low levels to health care provider.
<ul style="list-style-type: none"> • Use cautiously in patients with pituitary or adrenal insufficiency due to hormones from these sources playing a role in regulating blood glucose within a normal range. 	<ul style="list-style-type: none"> • Instruct patient to monitor blood glucose closely and report consistent high or low levels to health care provider.
<p>Evaluation of Outcome Criteria</p>	
<p>Evaluate the effectiveness of drug therapy by confirming that patient goals and expected outcomes have been met (see “Planning”).</p>	