

This form allows a person who is already registered for the NDSS to apply for access to insulin pump consumables through the Scheme.

Person with diabetes

1 Given name(s)

2 Family name

3 Date of birth

Day	Month	Year
/	/	

If person with diabetes is under 15 years old, the "Guardian or carer" section must also be completed.

4 Medicare card (preferred) or DVA file number

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5 Optional NDSS card number

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6 Which insulin pump are you using (or will be using)?

Brand:	Model:
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7 Are you of Aboriginal or Torres Strait Islander origin?

Tick all boxes that apply.

No

Yes, Aboriginal

Yes, Torres Strait Islander

8 Can we contact you about research opportunities?

Yes No

9 By signing here, you are confirming that any insulin pump consumables supplied to you by the NDSS are for only your own use, the information you have provided on this form is true and complete, and you agree to the collection, use and disclosure of your information for the purposes set out in this form.

Signed	Dated
	/ /

Guardian or carer

If the person with diabetes is under 15 years old, or is an adult receiving ongoing care, this section must be completed by a primary guardian or carer.

10 Given name(s)

11 Family name

12 By signing here, you are confirming that:

- you are a primary guardian or carer for the person named in Q1 and Q2;
- any insulin pump consumables supplied to you by the NDSS are for use only by the person with diabetes;
- the information you and the person with diabetes have provided on this form is true and complete; and
- both you and the person with diabetes agree to the collection, use and disclosure of the provided information for the purposes set out in this form.

Signed	Dated
	/ /

Lodging this form

Must be certified (on right) by your health professional.

Post: GPO Box 9824 in your capital city

Fax: 1300 536 953

Email: ndss@diabetesaustralia.com.au

Need help with this form?

Call **1300 136 588** or visit ndss.com.au

TTY: 133 677

Speak and Listen: 1300 555 727

Translation: 131 450

Internet Relay: internet-relay.nrscall.gov.au

Your information is protected by Commonwealth laws including the *Privacy Act 1988*. Diabetes Australia and our Agents are committed to protecting your privacy. For our privacy policy visit ndss.com.au or call **1300 136 588**.

Certifier

Only to be completed by an endocrinologist, relevant registered medical practitioner (e.g. obstetrician), or credentialed diabetes educator (CDE).

13 Person with diabetes' diagnosis

Type 1 Go to **14**

Gestational (GDM) Go to **19**

Type 2 *Do not continue with this form.*

Other *The person with diabetes must contact their state or territory diabetes organisation for further information.*

14 When did the person start using an insulin pump?

Month	Year
/	

or

Hasn't started yet Go to **21** (next page)

15 Is the date in Q14 before 1 September 2004?

Yes Go to **17** (next page)

No Go to **next question**

16 Have they turned 18 within last 6 months (see Q3)?

Yes Go to **17** (next page)

No Go to **22**

Form continues on next page

17 What is likely to result from withdrawal of insulin pump therapy? Tick all boxes that apply.

- Glycosylated haemoglobin level (HbA1c) higher than 7%
- Recurring hypoglycaemia
- Repeated "dawn phenomenon" (overnight fasting blood sugars higher than 9mmo/L)
- Severe glycaemic excursions

18 How many boxes are ticked in Q17?

- 1 or more Go to 32
- None Go to 31

19 Baby's expected date of birth

Day	Month	Year
/	/	

20 Go to 26

21 Is the person with diabetes under 18 (see Q3)?

- Yes Go to 26
- No Go to 22

22 For at least 3 months before today, has the person been on a prescribed regimen of multiple insulin injections each day, of varying dosage?

- Yes Go to 23
- No Go to 31

23 For at least 2 months before today, is there evidence of testing for glucose levels at least 3 times per day?

- Yes Go to 24
- No Go to 31

24 While the person has been on multiple daily injections, what has happened? Tick all boxes that apply.

- Glycosylated haemoglobin level (HbA1c) higher than 7%
- Recurring hypoglycaemia
- Repeated "dawn phenomenon" (overnight fasting blood sugars higher than 9mmo/L)
- Severe glycaemic excursions

25 How many boxes are ticked in Q24?

- 1 or more Go to 26
- None Go to 31

26 Has the person with diabetes (or their guardian/carer) completed a comprehensive diabetes education program provided by a diabetes team consisting of at least a CDE, and either an endocrinologist or another relevant registered medical practitioner (e.g. an obstetrician)?

- Yes Go to 27
- No Go to 31

27 Has the person (or guardian/carer) demonstrated competence in insulin pump function and operation, including insulin adjustment?

- Yes Go to 28
- No Go to 31

28 Most recent HbA1c result

%

29 When will pump therapy start?

Month	Year
/	

30 Go to 32

31 Do not continue with this form.

*The person with diabetes is **not eligible** for insulin pump consumables under the Scheme.*

32 Which are you? Choose one only.

- Endocrinologist Go to 33
- CDE Go to 33
- Other registered medical practitioner Describe:
- None of the above You cannot certify this form

33 Your full contact details OK to use stamp

Your name
Medicare provider number/CDE number
Clinic/Hospital name
Address line 1
Address line 2
Suburb
State
Postcode
Phone number
Fax number

34 By signing here, you are confirming that you have assessed the person named in Q1 and Q2, and that they have a clinical need for insulin pump therapy, as indicated by your answers to Q13 through Q30.

Signed 	Dated / /
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OFFICE USE ONLY

NDSS card number

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Processed by

on

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