Patient/Family Agreement for Insulin Pump Therapy

Note: In this Agreement, “You” refers to the child/adolescent and/or his/her parent/guardian, as appropriate. “The Patient” refers to the child/adolescent who will be using the insulin pump.

I ______________________________ wish to initiate Insulin Pump Therapy.

Please check (√) each box to indicate you have read and agree with each statement.

☐ You and your family have discussed the benefits and challenges of pump therapy and have decided that you would like to pursue insulin pump therapy.

☐ You and your family have reviewed and completed the “Are You Ready to be a Pumper?” document with members of your family and your diabetes health care team.

☐ You and your family have demonstrated competency in:

☐ Insulin adjustment
☐ Carbohydrate counting
☐ Managing diabetes during illness
☐ Self-blood glucose monitoring (regular testing, recording, and acting on the results)

☐ You and your family have attended a Diabetes Centre Insulin Pump Therapy Education Program (individual and/or group) and have done the required home reading, preparation, and follow-up.

☐ You and your family have realistic expectations about what an insulin pump can and cannot do and about the time commitment involved in beginning and continued use of an insulin pump.

☐ You and your family are prepared to attend regular follow-up appointments (minimum 2 times a year), as determined by your diabetes health care team.

☐ You and your family have established a personalized A1C goal (ultimately an age-appropriate target) with your diabetes health care team and are taking steps to move toward/attain this goal.

☐ You and your family agree to at least 2 A1C tests in a year.

☐ You and your family agree that in the case of worsened diabetes control, frequent adverse events (e.g., severe hypoglycemia and/or DKA episodes), or demonstration of poor judgment, pump therapy may be discontinued for safety reasons at the recommendation of the diabetes health care team.

For Younger Children

☐ You acknowledge that school and day care staff can assist with insulin pump therapy but cannot determine doses or manage pump problems and, as a result, you will:

☐ have a plan for pump operation when the child is out of your care;

☐ be available at all times in case there is a problem with the insulin pump.

I acknowledge that if I do not comply with these terms, I will no longer be eligible for the Nova Scotia Insulin Pump Program (NSIPP) and may have to discontinue the insulin pump and manage my diabetes with injections.

NOTE: If it is recommended to discontinue the insulin pump and manage your diabetes with injections, your diabetes healthcare team will offer education and support to help improve your diabetes self-management skills. By improving diabetes routines, knowledge, and motivation, it is possible to re-start the insulin pump under the NSIPP.

Name of Parent /Caregiver (PRINT) Name of Parent /Caregiver (Signature) Date (mm/dd/yyyy)

Name of Patient (PRINT) Patient Signature (if appropriate) Date (mm/dd/yyyy)