Insulin Pump Patient Responsibility Agreement

I, ____________________________, [name of person signing], have met the provincial criteria for myself or ____________________________, [patient name] for the management of diabetes.

In order to continue to use the insulin pump, I understand that I must fulfill the following requirements. These will be reviewed at clinic visits:

- I will not have more than 1 hospitalization with Diabetes Ketoacidosis (DKA) in the next 12 months.
- I will have at least three A1C measurements within the next 12 months (at least 90 days apart).
- I will ensure that no more than 1 of these A1Cs is above 9%; child under 6 years of age 9.5%
- I will check my blood glucose at least 4 times per day and record or download results at least weekly, bringing these results to any clinic visits.
- I will check for ketones when I am sick or have a blood glucose level higher than 15-18 mmol/L.
- I will keep a written record of basal/bolus settings in case of pump failure.
- I will consistently demonstrate safe and appropriate use of my pump, including:
  - Giving boluses for food intake
  - Setting basal rates that meet my body's needs
  - Use of recorded results to make or ask for insulin adjustments
  - Changing & rotating infusion set every 2-3 days
- For patients under age 18:
  - I will provide ongoing support in the diabetes management of my child or dependent adult
  - I will have in place a written, updated plan for managing the pump while my child is in the care of other individuals, schools or treatment centers.
  - I will see the Pediatric Team regularly & as needed. If applicable, MEDEC & Pediatrician in Regina in between.
  - Minimum of 1 in-person contact per year in Pediatric Diabetes Clinic in Saskatoon clinic with other contacts as needed ie telephone, fax, email, in-person nurse or dietitian appointments as needed.

I have read the above conditions and agree that if I do not comply with them I may be asked by the Pediatric Diabetes Clinic team to remove the insulin pump and manage my diabetes with injections or have the 5 year renewal of a new pump not signed.

Signed this ______ day of __________, 20____ in the city of ________________, Province of Saskatchewan.

Patient name ____________________________
Printed name of guardian ____________________________ Guardian signature ____________________________
Printed name of witness ____________________________ Signature of witness ____________________________

Reference: Adapted from Alberta Health Services – Alberta Children’s Hospital