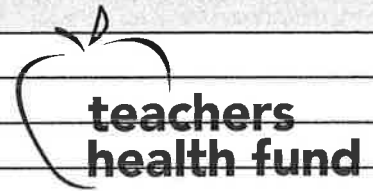


Section 1: To be completed by the provider



Patient name:	Patient date of birth:
Membership number:	
Signature of member or guardian (and guardian name):	
Name and specialty of provider:	
Signature of provider:	Date of signing:

Contact information for provider
Phone:
Fax:
Email:

Details of new device
Name:
Model number:
Prostheses rebate code:

Please specify dates of insulin pumps previously funded.

Current insulin pump	Name: Model number:
----------------------	------------------------

Is the insulin pump sought an: 1. Upgrade OR 2. Replacement

Is the current device still functioning? Yes No

If "yes" what is the reason for the upgrade?

Provide details of any repairs to this device (including date - attach additional sheet if required):

Has the patient been on a prescribed regime of multiple insulin injections? Yes No
If Yes, for how long? Years Months
Number of injections per day:
Varying dosage: Yes No

Please provide details of glucose testing for the previous three months (attach additional sheet if required):

Has the patient completed a diabetes education scheme? Yes No
Please specify location and facilitator:

Within the last 3 months has the patient experienced a Glycosylated haemoglobin level (HbA1c) greater than 8%? Yes No



