## **Dexcom G4-G5 Order Form**

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| <b>Note:</b> All fields in red below are required.  |                                     |                                 |   |                  | Date:                           |                      |                  |          |          |  |
|---|-------------------------------------|---------------------------------|---|------------------|---------------------------------|----------------------|------------------|----------|----------|--|
| Customer Details  |                                     |                                 |   |                  |                                 |                      |                  |          |          |  |
| Customer Full Name:   |                                     |                                 | Address:  |                  |                                 |                      |                  |          |          |  |
| Date of Birth:  |                                     |                                 | Street Address:   |                  |                                 | Suburb:              |                  |          |          |  |
| Phone:  |                                     |                                 |   | -                |                                 |                      |                  |          |          |  |
| Email:  |                                     |                                 |   | State: Postcode: |                                 |                      |                  |          |          |  |
| I agree to the terms and condi<br>I agree that, before I use the p<br>healthcare professional or AM   | roduct, I will r                    | eview all t                     | he training   | materia          | al provided. If I need          | further training,    | l will contact n | ny       | nased.   |  |
| Customer Signature:   |                                     |                                 |   |                  |                                 |                      |                  |          |          |  |
| Hospital/Clinic Contact   | Details                             |                                 |   |                  |                                 |                      |                  |          |          |  |
| Healthcare Professional Name:   |                                     |                                 | Clinic Address:   |                  |                                 |                      |                  |          |          |  |
| Hospital/Clinic Name:   |                                     |                                 | Street Address: Suburb:   |                  |                                 |                      |                  |          |          |  |
| Troopital of the real of  |                                     |                                 |   |                  |                                 |                      |                  |          |          |  |
| Phone:  |                                     |                                 |   | -                |                                 |                      |                  |          |          |  |
| Email:  |                                     |                                 |   |                  |                                 |                      |                  |          |          |  |
| Dexcom Start Date:  |                                     |                                 | State: Postcode:  |                  |                                 |                      |                  |          |          |  |
| AMSL Diabetes Representativ   | e Name:                             |                                 |   |                  |                                 |                      |                  |          |          |  |
| Delivery Address (no Po   | D Box)                              |                                 |   |                  |                                 |                      |                  |          |          |  |
| ☐ Home Address  |                                     |                                 | Clinic Address (I have informed my clinic and HCP that this order is being sent here) |                  |                                 |                      |                  |          |          |  |
| Other (please specify):   |                                     |                                 |   |                  |                                 |                      |                  |          |          |  |
| Dexcom Order Details  |                                     |                                 |   |                  |                                 |                      |                  |          |          |  |
| Please note: If you are using your smart device<br>a full list of compatible smart devices, visit dex | e as your display<br>com.com/dexcom | device, pleas<br>n-internationa | se check that<br>al-compatibilit  | t your sm        | art device is compatible v      | with the Dexcom G5 I | Mobile app prior | to purch | ase. For |  |
| Dexcom G5® Mobile   |                                     | Price                           | Qty   | Dex              | com G4® PLATI                   | NUM                  | Pri              | се       | Qty      |  |
| Dexcom G5 Mobile Kit<br>1x Transmitter (3-month life)<br>1x Dexcom Sensor 4 Pack (28 days o           | f use)                              | \$910                           |   |                  | com G4 PLATIN<br>onth warranty) | UM Transmitt         | er <b>\$5</b> 6  | 80       |          |  |
| Dexcom G5 Mobile Transmitter (3-month life)   |                                     | \$540                           |   | Dex              | com G4 PLATIN                   | UM Receiver          | \$8              | 10       |          |  |
| Dexcom G4/G5 Sensor 4 Pack (28 days of use)   |                                     | \$370                           |   |                  | com G4/G5 Sen<br>ays of use)    | sor 4 Pack           | \$3              | 70       |          |  |
| Dexcom G5 Mobile Receiver \$  |                                     | \$650                           |   |                  | com G4 Sensor<br>ays of use)    | 1 Pack (trial)       | \$9              | 5        |          |  |
| Payment Information   |                                     |                                 |   |                  |                                 |                      |                  |          |          |  |
| Total (\$): Card No:  |                                     |                                 | CVC:  |                  |                                 |                      |                  |          |          |  |
| Expiry:   | Cardholder Name:                    |                                 |   |                  |                                 |                      |                  |          |          |  |
| OR, I have paid for the f   | ull order or                        | nline                           |   |                  |                                 |                      |                  |          |          |  |
| Total amount will be charged. Payme   | nt information                      | n must be                       | complete  | ed prio          | r to submitting ord             | er form or the o     | rder cannot l    | oe pro   | cessed.  |  |

Alternatively, you can complete your payment at www.amsldiabetes.com.au/shop. Amex cards will incur a 1.25% surcharge.

Please email completed form to diabetes@amsl.com.au

For more information on Dexcom, please contact the AMSL Diabetes Customer Care Team on 1300 851 056.

amsIdiabetes.com.au 🕧 💟 🎯 🕞







