This form should be completed by the patient and/or their parent/carer and an NHS diabetes specialist.

**Agreement to use the flash glucose scanning (FGS) system**

You have been given an FGS system and the Diabetes Team expect you to take responsibility for using it correctly.

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| **Patient’s name** |  | **Unit/Hospital number** |  |
| **Consultant name** |  | **Paediatric diabetes specialist nurse (PDSN)** |  |

**I/We agree to:**

* Attend the recommended FGS training and take the advice of the diabetes team to understand what the device is showing and what action to take
* Perform at least four scans per day as well as using standard blood glucose testing strips as advised by the diabetes team
* Attend follow-up appointments as requested by my diabetes team
* Share blood glucose testing and FGS scanning information with my diabetes team
* Contact Abbott for further supplies if the sensor falls off before it is due to be changed
* Use my standard blood glucose testing strips if I lose any sensors

**I/We understand that the sensors will no longer be provided if:**

* The sensor is worn for less than 70% of the time
* Scans are carried out less than four times per day
* Appropriate actions, as advised by the diabetes team are not carried out
* The results below have not been achieved by the six-month review or improvement is not maintained at each annual review *[Delete as appropriate. All criterion specified in the FGS policy for the relevant indication must remain*]
  + Improved hypoglycaemia awareness
  + A reduction in the number of hypoglycaemic events
  + A reduction in the number of diabetic ketoacidosis events
  + An improvement in HbA1c of 5 mmol/mol or greater
* No longer fulfil the criteria for funding
* Do not fulfil the criteria for funding in people over the age of 19 on reassessment at transition to adult services

Funding for sensors is for a time-limited period. FGS are a developing technology and therefore the current funding agreement will be reviewed regularly. I/We understand that:

* A maximum of 26 sensors will be provided over a 12-month period
* Funding for treatment may be stopped in the future

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| --- | --- | --- | --- |
|  | **Patient** | **Parent/carer** | **Consultant/PDSN** |
| Signed |  |  |  |
| Print name |  |  |  |
| Date |  |  |  |