Newfoundland Labrador

Verification of Medical Eligibility

Newfoundland and Labrador Insulin Pump Program

HCN: _____

Province/Territory: _____ Expiry: _____

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F ☐ UN

Mailing Address: _____

City: _____

Province/Territory: _____ Postal Code: _____

Telephone: (Indicate Preferred) ☐ Home _____

☐ Cell _____ ☐ Work _____

Ordering Provider's Name: _____	**Clinic Stamp**:(include fax, provider and mnemonics)
Clinic Name: _____	
Mailing Address: _____	
City: _____	
Province/Territory: _____ Postal Code: _____	Ordering Provider's Meditech Mnemonic: _____
Phone: _____ Fax: _____	EMR Clinic Mnemonic: _____
Signature: Date:	COPY TO PROVIDER

For applicants under the age of 18 years, prescriber certification must be by a physician specialist.

PRESCRIBER CERTIFICATION – INITIAL APPLICATION - **NEW to insulin pump therapy.**

This is to certify that the above applicant has Type 1 Diabetes and meets **ALL** specified criteria for **INITIAL** insulin pump therapy:

- ☐ Participates in regular appointments with diabetes health care team at least three times per year (or at a frequency deemed appropriate by the diabetes health care team);
- ☐ Performs self-monitoring of blood glucose at least three times per day;
- ☐ Demonstrates motivation to achieve and maintain improved glycemic control;
- ☐ Has completed comprehensive diabetes education, including carbohydrate counting.

PRESCRIBER CERTIFICATION – ANNUAL RENEWAL - **CONTINUATION of insulin pump therapy**

This is to certify that the above applicant has Type 1 Diabetes and meets **ALL** specified criteria for **CONTINUATION** of insulin pump therapy, including:

- ☐ Participates in regular appointments with diabetes health care team at least three times per year (or at a frequency deemed appropriate by the diabetes health care team);
- ☐ Rotates insertion sites every three days;
- ☐ Demonstrates appropriate sick day knowledge and management;
- ☐ Has not had more than one diabetic ketoacidosis (DKA) event in the previous six months;
- ☐ Demonstrates the ability to safely self-manage blood glucose on insulin pump therapy.

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Telephone: (Indicate Preferred) ☐ Home _____

☐ Cell _____ ☐ Work _____

This personal health information is being collected and used under the authority of s. 29 and s.34(a)(m) of the Personal Health Information Act, and will be used assess and verify eligibility for the NLIPP. If you have concerns about the collection, use or disclosure of your personal health information, please contact the privacy office of your organization

I consent to the sharing of this information with appropriate employees of the NLIPP and vendor of my choice for insulin pump therapy and supplies

Applicant/Guardian Signature _____ Date: _____

Please note all sections of the form must be completed for processing. Incomplete or illegible forms will be returned. Scanned documents (PDF version) is preferred.

Forward completed form to: Newfoundland and Labrador Insulin Pump Program, Diabetes Education Center, Suite 206, 35 Major's Path, St. John's, NL, A1A 4Z9
Email: NLIPP@easternhealth.ca, Fax: 709-752-3639, Tel: 709-752-4436 or toll free 1-888-246-4888