**Template continuation criteria confirmation –** **flash glucose monitoring**

Dear *Insert GP name*

The above person with diabetes on insulin has been assessed following a trial of flash glucose monitoring device (Freestyle Libre 2®) as previously communicated to you on ………………... as they fitted the Pan Mersey APC criteria for commencement of this.

The following criteria for initiation were met at this time (**please tick box(es) to confirm those that applied when flash glucose monitoring was commenced**):

🞏 Diabetes in cystic fibrosis on insulin treatment

🞏 Type 1 diabetes, or any form of diabetes on haemodialysis on insulin and clinically routinely requires more than 8 blood glucose tests per day

🞏 Type 1 diabetes currently pregnant (total 12 months treatment anticipated including post-natal period)

🞏 Type 1 diabetes unable to self-monitor due to disability and requires carer support to do so.

🞏 Type 1 diabetes and occupational circumstances (working in insufficiently hygienic conditions to safely facilitate finger-prick testing or where it is highly impractical to conduct finger-prick testing due to the practical requirements of their occupation) that warrant use of flash glucose monitoring.

State occupation and reason………………………………………………………………

…………………………………………………………………………………………………

🞏 Type 1 diabetes transitioning between paediatric and adult services with psychosocial circumstances that warrant flash glucose monitoring, with appropriate adjunct support from a formal service that manages these issues.

🞏 Type 1 diabetes with impaired awareness of hypoglycaemia (Gold score 3 - 5) and it is anticipated that use of flash glucose monitoring is the most appropriate option.

🞏 Type 1 diabetes with recurrent severe hypoglycaemia.

🞏 Type 1 diabetes - previous self-funders where clinical history suggests that they would have satisfied one or more of the above criteria prior to them commencing use of flash glucose monitoring had these criteria been in place prior to April 2019 AND have shown improvement in HbA1c since self-funding.

🞏 Diabetes and a learning disability who use insulin to treat their diabetes.

**The above person has been assessed again (insert date ………………………..(at no more than 6 months from commencement) and the following has been found:**

🞏 has **not** met the continuation criteria or does not wish to continue use – **please discontinue prescribing flash glucose monitoring.** Please prescribe blood glucose monitoring instead as advised below:

Device………………………………………

Frequency of testing………..…………….

🞏 **has** met the continuation criteria as confirmed below - **please continue prescribing flash glucose monitoring**

(You must indicate by ticking boxes below to indicate which criteria have been met or flash glucose monitoring prescribing will be stopped) –

🞏 I confirm they have had a clear reduction in routine number of blood glucose tests (excluding those needed for management of intercurrent illness, mealtime BG tests for bolus calculator users, or tests for hypoglycaemia) where more than 8 blood glucose tests per day as above was the initial reason for starting flash glucose monitoring.

🞏 Pregnancy ongoing – please discontinue after total 12 months use.

🞏 Continues to require third party monitoring due to disability.

🞏 Occupational circumstances that warrant use are continuing.

🞏 Psychosocial circumstances that warrant use are continuing.

🞏 Impaired awareness of hypoglycaemia (Gold score 3 - 5) and use of flash glucose monitoring has clinically significantly improved HbA1c, time in range, symptoms of diabetic ketoacidosis or hypoglycaemia.

🞏 Reduction in severe hypoglycaemia / reduction in hospital admissions

🞏 Previous self-funder, continues to show improvement in HbA1c

🞏 Learning disability

Specialist signature…………………………………………………..Date………………