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

Dear *Insert GP name*

The above person with diabetes on insulin has been assessed and fits the Pan Mersey APC criteria for commencement of a trial of flash glucose monitoring device (Freestyle Libre 2®).

The following criteria have been met (**please tick box(es) to confirm those that apply**):

🞏 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

**In addition** (please carry out all items below and tick to confirm):

🞏 I confirm the person has undergone structured training in use of flash glucose monitoring and has shown they are able to adequately use it

🞏 I confirm the person has agreed to attend appointments arranged by me during the next period of up to 6 months to assess ongoing fulfilment of criteria for continuation of flash glucose monitoring

🞏 I confirm the person has received written information describing their commitment to appropriate use of flash glucose monitoring and they understand prescribing will be discontinued if they do not fulfil this commitment, or fail to meet the improvement criteria necessary for prescribing to be continued

🞏 I confirm audit data will be submitted to national ABCD audit unless the person does not give consent to this. Consent given: 🞏 Yes 🞏 No (please tick which)

🞏 I confirm I will write to you again in 6 months or before to confirm whether continuation criteria are met or not (if no confirmation received by 6 months then prescribing should be stopped by you)

🞏 I confirm the person will continue to be reviewed by the clinic and it will carry out the review of the downloaded data from the device when assessing the person’s response, during the 6-month (or less) assessment period

🞏 I have included a copy of the Personal Agreement signed by the person with this document, for your information.

**Prescribing instructions to GP**: please prescribe 2 Freestyle Libre 2® sensors per month. The Freestyle Libre 2® device has been supplied by us (not prescribable on FP10) and should any replacement device be needed the person may obtain one free of charge from manufacturer or from this clinic.

**Blood glucose strips will still need to be prescribed but in lower quantities than previously**. They will still be needed for mealtime BG tests for bolus calculator users, or tests for hypoglycaemia.

Revised recommended frequency/ circumstances of blood glucose monitoring ……………………………………………………………………………………………….

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Details of Blood glucose monitoring device etc………………………………………..

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Hyperlink to Freestyle Libre 2® information (e.g. manufacturer website)

Date of 6-month (or earlier) review……………………………

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