Continuous Glucose Monitoring

BEFORE providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate **EXPLICIT CONSENT** for sensitive and personal information on this form to be passed to the Funding Team/CCG/CSU for processing.

Consent given: Yes ☐

Please ensure a secure NHSmail email account (nhs.net) is used to submit this form.

Patient First name		**Patient Surname**		**Hospital**	
NHS No.		**Date of Birth**		**Consultant**	
GP F-code		**CCG**		**UBRN**	
Hospital No.		**Referrer**			

Additional information

Please submit completed form to the following email address:
bbccg.mseccg-funding@nhs.net

A decision will be made and the form returned within 3 working days where all relevant information is provided.

N.B: Please ensure forms are clear and legible. Illegible forms will be returned to sender.

Individual Prior Approval is required in all cases.

Funding for real-time continuous glucose monitoring (CGM) with alarms for children or young people with type 1 diabetes will be considered on a case by case basis only, when despite optimised management, the patient has ONE or more of the criteria below:		**Please Tick ✓**
	• Frequent severe hypoglycaemia	
OR	• Impaired awareness of hypoglycaemia associated with adverse consequences (e.g. seizures)	
OR	• Inability to recognize or communicate about symptoms of hypoglycaemia (e.g. because of cognitive or neurological disabilities)	
Requests for funding CGM in adults with Type 1 diabetes will be considered on a case by case basis only when despite optimised management the patient has:		
	• Complete loss of awareness of hypoglycaemia OR • Frequent (more than 2 episodes a week) asymptomatic hypoglycaemia that is causing problems with activities of daily living.	

Please supply information clearly evidencing the selected criteria above (where applicable)

CCG USE:	**Invoice ref:**	**Prior Authorisation requested by:**	
Is the procedure approved or declined? **Please indicate:**		**Name of Clinician**	
Name		**Contact number**	
Signature		**Date**	
Date			