Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Patient Agreement to Self-Manage Insulin Pump In-Hospital

(To be read and signed by patient / guardian and placed in patient chart)

For your safety and optimal medical care during hospitalization, we request that you review this form outlining what is expected of you in hospital to self-manage your diabetes with your insulin pump. If you feel that you cannot carry out these responsibilities, we would like to treat your diabetes with insulin injections and/or intravenous insulin and discontinue the use of your insulin pump.

These are the responsibilities for self-management of your insulin pump during your hospital stay:

1) Understanding the potential risk of using your insulin pump in the hospital:
   a) high and low blood glucose
   b) diabetic ketoacidosis; and
   c) infection

2) Completing the **Insulin Pump Information Sheet** *(Form # 20114)* which will provide all pump settings to your Physician or Most Responsible Health Practitioner.

3) Providing all necessary supplies to run your insulin pump:
   a) insulin pump
   b) insulin cartridge or pods
   c) tubing and infusion sets
   d) extra batteries for the pump
   e) dressings (if applicable); and
   f) insulin – only if non-formulary such as [glulisine (Apidra®)]

4) Changing the infusion set every 48-72 hours or sooner as needed for:
   a) skin problems; or
   b) if two blood glucose readings are greater than 14.0 mmol/L (with trace/negative ketones) in 4 hours
   c) immediately if blood glucose reading greater than 14.0 mmol/L and **positive** for ketones

5) Allowing hospital staff to test your blood sugar a minimum of 4 times per day (prior to meals and bedtime) using a hospital blood glucose meter.
   a) you may test more often using your own home blood glucose meter/flash glucose monitor(Flash)/continuous glucose monitor(CGM)
   b) if using a home blood glucose meter/flash glucose monitor(Flash)/continuous glucose monitor(CGM), you must still allow hospital meter testing.

6) Allowing hospital staff to test **ketones** if blood glucose values are greater than 14.0 mmol/L

7) Completing the **Insulin Pump Therapy Patient Bedside Logbook** *(Form # 20189)* daily

8) Informing nursing staff if:
   a) you have any signs and symptoms of low blood sugar
   b) blood sugar less than 4.0 mmol/L
   c) blood sugar 14.0 mmol/L or greater
   d) you are pregnant and the majority of your sugars are over 7.0 mmol/L
   e) you have a problem with your pump and/or if you called the pump company's 24 hour "1-800 assistance line"; or
   f) you feel like you can no longer self-manage your pump

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9) Understanding that your insulin pump **may be discontinued** and a different insulin delivery provided for if any of the following occurs:
   a) Physician or Nurse Practitioner's order
   b) you are not physically, emotionally or mentally capable of managing the insulin pump at the time
   c) undergoing a radiology procedure other than an ultrasound
   d) having a procedure under a general anesthetic
   e) other reasons deemed necessary by your attending physician or most responsible health care provider where the use of the insulin pump is risky or non-effective
   f) you choose not to or are unable to participate in self-care or to agree to self-management terms

☐ I have read what is expected of me to self-manage my diabetes using my insulin pump in hospital. I am satisfied with and understand the information I have been given, and I agree to fulfill the self-management responsibilities.		
Patient/Guardian *(print)*	Patient/Guardian *(sign)*	Date *(dd-Mon-yyyy)*