**Manitoba Adult Insulin Pump Program (MAIPP)** 

**REFERRAL FORM**

**PLEASE COMPLETE Sections 1, 2, 3 A, 3 B, 3 C and A1Cs, incomplete forms will cause delays**

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| **SECTION 1 – PRESCRIBER DETAILS**Physician / Practitioner Name and mailing address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facsimile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SECTION 2 – PATIENT INFORMATION**Patient Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Manitoba Health (6 digit): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHIN (9 digit): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: (DD/MM/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number(s), including area code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address (Including Postal Code):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SECTION 3 – PLEASE COMPLETE ALL APPROPRIATE BOXES** |
| **3 A. PATIENT ELIGIBILITY (must meet all criteria in 3 A, please check boxes to indicate criteria met)****□** Patient has not receivedan insulin pump under any Manitoba Insulin Pump Program within the last 5 years**☐** Type 1 Diabetes **☐** >18 years of age and is a Manitoba resident |
| **3 B. CURRENT DIABETES MANAGEMENT*****Basal Bolus Therapy* *Insulin Pump User – has warranty expired*** **☐** YES **☐** NOBasal Insulin + Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiry date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **☐** UnknownI:C ratio or other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insulin Pump Model: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3 C. GLUCOSE MONITORING (please check box to indicate)****☐** Capillary glucose monitoring  **☐** Dexcom **☐** Libre 1 or 2 **☐** Medtronic G3**REMINDER:** Patient must perform minimum 4 times daily and provide minimum 2 weeks of recent glucose logs |
| **Please provide two most recent HbA1c results**A1c \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A1c \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| I have discussed with the patient that the purpose of releasing their information to the Manitoba Adult Insulin Pump Program is for training if eligible for the insulin pump they select. Patients are responsible to fund their insulin pump supplies which are eligible under pharmacare. This facsimile is Doctor-Patient privileged and contains confidential information intended only for MAIPP. Any other distribution, copying or disclosure is strictly prohibited. If you have received this fax in error, please write “MISDIRECTED” across the front of the form and fax to **1-204-940-2193**, then destroy the pages received in error. |
| **Prescriber’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FAX COMPLETED FORM TO 204-940-2193**