Saskatchewan Aids to Independent Living (SAIL)
Insulin Pump Program – Pediatric Registration

- Complete the Pediatric Registration form for your files
- Register by email **ATTN: PEDIATRIC REGISTRATION Insulin Pump Program** and allow a minimum of 72 hours for confirmation

Drug Plan and Extended Benefits Branch
3475 Albert Street
Regina, SK S4S 6X6
Phone: 306-787-7121
Fax: 306-787-8679
Email: EHB@health.gov.sk.ca

Client Information (Please Print)

Last Name	First Name	Middle Initial

Saskatchewan Health Services Number (9 digits)										Date of Birth mm dd yyyy

Name of Parent/Guardian	Relationship:

Confirmation of Client's Eligibility for an Insulin Pump

☐ Client has Type 1 diabetes

Client has demonstrated ongoing and sustained practice of the following diabetes-related activities for a minimum of 6 months prior to the insulin pump trial:

☐ There is demonstration of involvement of a parent(s)/guardian(s) in diabetes management. Child/youth/family has completed all steps of the Saskatchewan Pediatric Endocrinology and Diabetes Program: Insulin Pump Assessment Process, part of which includes attendance at a Pediatric Diabetes Pump Information Session or completion of the *Is Pump Therapy for Me?* online modules and quiz.

☐ Blood glucose monitoring four (4) or more times per day or appropriate use of a continuous glucose monitor (CGM) or flash glucose monitor (FGM).

☐ Consistency and accuracy in carbohydrate counting.

☐ Ability to self-assess and take action based on blood glucose results.

☐ Safe and effective management of hypoglycemia and hyperglycemia.

☐ A commitment to long-term diabetes follow-up through regular assessments occurring at least annually (every 12 months) by a diabetes education program, diabetes educator, or their authorized specialist physician.

☐ Expressed expectations or goals that are in line with potential outcomes of pump therapy.

☐ No unacceptable burden of diabetic ketoacidosis as determined by a diabetes education program, diabetes educator, or their authorized specialist physician.

☐ Consistent A1C monitoring at an interval of approximately every three (3) to six (6) months, or as deemed appropriate by a diabetes education program, diabetes educator, or their authorized specialist physician.

Note – applications will be considered incomplete if all criteria are not confirmed.

Physician's Certification of Eligibility

To be completed by a pediatric endocrinologist or a pediatrician with diabetes expertise who is associated with the SHA Pediatric Diabetes Program and has experience with insulin pump management in children.

Name (PLEASE PRINT)	Telephone Number (include area code)

Signature: Date:

Diabetes Education Program:

Diabetes Educator's Certification of Eligibility

To be completed by an SHA diabetes educator who works with the SHA pediatric diabetes education program.

Name (PLEASE PRINT)	Telephone Number (include area code)

Signature: Date:

Certification of Completed Insulin Pump Trial

To be completed by an SHA diabetes educator who works with the SHA pediatric diabetes education program.

☐ The candidate was assessed through the SHA pediatric diabetes education program process.

☐ Client continues to demonstrate acceptable standards of personal diabetes management.

☐ Client has completed a trial period (up to three months) that confirms that the Insulin Pump is medically appropriate for use.

☐ A certified pump trainer has confirmed that the client has an adequate level of knowledge to operate the pump and safe use of the device is achieved.

Date client started the Insulin Pump:

Name (PLEASE PRINT)	Telephone Number (include area code)

Signature: Date:

Insulin Pump and/or Supplies Specifications

Client requirements:	
☐ Insulin pump and supplies	☐ Insulin pump supplies only
Insulin Pump Brand:	Date Insulin pump was started:
Insulin Pump Model:	Brand and model of current insulin pump:

Client (parent/caregiver) Consent and Authorization and Confirmation of Responsibility

The collection of personal health information on this form by the Ministry of Health is necessary for the purposes of assessing and verifying eligibility for the SAIL Insulin Pump Program and for other purposes related to the administration of that program. ☐ Yes

In accordance with the Health Information Protection Act (Saskatchewan), and with your expressed consent, selected personal health information on this form may be used by or disclosed to appropriate employees of the SHA and the insulin pump supplier (as selected by the applicant and designated on this form). This information will only be provided on a need-to-know basis with your consent.

I consent to the collection, use and disclosure of my personal health information for the purpose outlined above, only for the period of time that I am eligible for benefits under the SAIL Insulin Pump Program. I understand that if I wish to withdraw this consent I may do so at any time by writing the SAIL program at the address on this form. I understand that withdrawal of consent would mean that I am no longer eligible for benefits.

I understand that the **insulin pump trial period** can be up to three months. During this time, the SHA Diabetes Education Program will assess the appropriateness of the pump for me and confirm that I have an adequate level of the knowledge and practices for the safe use of the device. During the three-month period, the pump may be returned to the company and the trial ended, based on medical reasons such as allergy to infusion set or other reasons the diabetes education program, diabetes educator, or the authorized specialist physician deems necessary. I understand I would then be responsible for returning the pump to the company and I may be charged with the full cost of the insulin pump if I fail to do so within the return policy period (determined by the company). ☐ Yes

I am aware of the **Insulin Pump Program Renewal Policy**, which occurs every five years. I understand that I am not eligible for additional Insulin Pump Program grant funding for the purchase of a new insulin pump prior to five years. ☐ Yes

Insulin Pump Program Discontinuation. I understand that coverage for insulin pump supplies may be discontinued at any time for a minimum of six months on the recommendation of a specialist physician if it is determined that the Insulin pump is no longer appropriate for my care. ☐ Yes

I am committed to ensuring I or my child maintains long-term diabetes follow-up through regular assessments occurring at least annually (every 12 months) by a diabetes education program, diabetes educator, or the authorized specialist physician. ☐ Yes

I have read and understand the Client (parent/caregiver) Consent and Authorization and Confirmation of Responsibility.

Signature: Date: