



Affix Patient Label

Patient Name:

Date of Birth:

Insulin Continuous Subcutaneous Infusion Pump Therapy Consent

Using an insulin pump is one of the best ways of controlling diabetes. There are times you may need to stop using the pump and replace it with an IV or shot form of insulin. For your safety and to provide the best medical care during your visit, we would like you to agree to this list:

- 1) I will show the nurse the pump’s programming that tells the continuous “basal” rate and the “bolus” dose the pump gives with each blood sugar.
- 2) I will change the infusion set or tubing and needle every 3 days and when:
 - a. There is skin problem, or
 - b. Unexplained blood glucose readings greater than 300 that don’t come down after a “bolus” of insulin or
 - c. No response to one correction “bolus” of insulin.
 - d. There are “ketones” in the urine at medium to high amounts.
- 3) I will use my own insulin pump supplies.
- 4) I will show or tell my nurse about the total amount of insulin I received when asked.
- 5) I will tell my nurse if I feel like I have low blood sugar.
- 6) I will tell my nurse if my pump isn’t working.
- 7) I will ask questions about the pump or the doctor’s orders.
- 8) If I can’t run my pump, or the person that usually helps me with the pump cannot help, the pump will be stopped and replaced with either an IV or shot form of insulin.
- 9) I agree to only use the blood glucose measurements performed with Bronson equipment.

I understand that my insulin pump might be stopped and a different kind of insulin delivery used if anything listed below happens:

- 1) A doctor orders it to be stopped.
- 2) I am too sleepy to help run the pump.
- 3) I have an X-ray test and the pump has to be removed.

Patient Signature: _____ Date: _____ Time: _____

Parent or Guardian Signature if patient is less than 18 years of age _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____