The Hillingdon Hospitals NHS
NHS Foundation Trust

Paediatric Department
Hillingdon Hospital
Pield Heath Road
Hillingdon
Middlesex
UB8 3NN

Tel: 01895 279566

Children and Young People with Diabetes (CYPD) Team

Email: XXXXXXXXXXX

Paediatric Diabetes Consultants:
Dr XXXXX XXXXXXXXX

Adult Diabetes Consultant:
Dr XXXXXXXXX

Paediatric Diabetes Specialist Nurses (PDSN):
XXXXXX

Paediatric Specialist Dietitians:
XXXX

Paediatric Clinical Psychologist:
XXXX

Administrator:
XXXX

PDSN Mobile: XXXXXXXXXX
Available 24/7 for urgent advice

Patient/Parent Agreement for Continuous Subcutaneous Insulin Therapy (Pump Therapy)

After deciding on Insulin Pump Therapy, the family and/or patient are asked to sign this written agreement committing themselves to necessary standards of care.

I ……. understand that the insulin pump I am being given to manage my/my child's diabetes remains the property of the NHS. Funding for the equipment that is required for the insulin pump is provided by the NHS.

I agree:

- to attend annual pump refresher education sessions
- to attend all 4 paediatric diabetes clinic appointments
- to utilise the pump fully/safely: test blood glucose levels, carbohydrate count, follow hyperglycaemia/hypoglycaemia rules.
- to contact the team when additional support is required or as soon as a problem is identified.

I understand that failing to attend appointments/ education sessions and follow clinical advice about my/ my child's pump therapy could result in funding being withdrawn. In these circumstances the insulin pump must be returned to the Children's Diabetes team.

Providing that the Children's Diabetes team and I feel that insulin pump therapy has been successful then the pump therapy can continue.

I acknowledge that while we have the insulin pump, we are responsible for its condition and will provide insurance against accidental damage or loss, including holiday insurance.

Patient…….
D.O.B…….
Signed (parent)……..…….
Patient……
Date……

Health Care Professional Name……
Signed/Date……