**APPLICATION FOR GLUCOMETER**

**PROVIDED BY**

**MEDICAL BENEFITS SCHEME**

Date: \_\_\_\_D\_\_\_\_M\_\_\_\_Y

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Contact Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beneficiary’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MBS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beneficiary’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beneficiary’s Contact Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_D\_\_\_\_\_M\_\_\_\_Y

**CLINICAL INFORMATION**

Please note that some of the information requested is for departmental research purposes and will not in any way influence the decision to provide the beneficiary with a glucometer.

Diagnosis date of Type 1 Diabetes: \_\_\_\_D\_\_\_\_M\_\_\_\_Y

Hospitalization history (if related to Diabetes

|  |  |  |
| --- | --- | --- |
| Date of Admission |  | Diagnosis |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Does the patient have any of the following complications?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Complication |  | Yes | No |  | Unsure |
| Retinopathy |  |  |  |  |  |
| Neuropathy |  |  |  |  |  |
| Nephropathy |  |  |  |  |  |
| Other Vascular Complications |  |  |  |  |  |

Current Prescription:

Recommended frequency of testing blood sugar

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby certify that the above-named patient has Type 1 Diabetes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature