

**REQUEST FOR SHORT-TERM PRESCRIBING FOR FREESTYLE LIBRE® -
indication 2**

Following a 2 month period, prescribing responsibility may be transferred to the GP for up to three months until expected outcomes are reviewed in clinic. Please send this request form after the usage review at 4 weeks post initiation.

Patient Details	GP Details
Surname	Name
Forename	Address
Address	
	Tel
Postcode	Fax
NHS No:	NHS.net email
DOB:	
SEX: Male / Female	

To be completed by the initiating specialist clinician	
Clinician Name:	
Clinic Name	
Clinic Address:	
Contact tel number:	
Fax number:	
NHS.net email:	
Signature:	
Date of usage review in clinic (at 4 weeks post initiation):/...../.....	
Next clinic appointment:/...../.....	
<p>Notes to the primary care practitioner – please clearly state expected monitoring and prescribing needed in primary care. Please append a copy of patient-prescriber agreement for reference. This contains full details of expected outcomes and should be referred to alongside this document.</p>	

Date Freestyle Libre® initiated:			
Tick the approved indication for Freestyle Libre®			
	Yes	No	Baseline values
Patients with type 1 diabetes with HbA1c > 8.5% (69.4 mmol/mol) or disabling hypoglycaemia who are eligible for insulin pump therapy as per NICE TA151			
Please detail outcomes expected and when these will be reviewed			
Number of months of acute prescriptions requested: months		

Primary care practitioner (PCP): Please complete and send this form back to the specialist clinic confirming whether or not you agree to prescribe FreeStyle Libre® until the next appointment. A copy should be retained in the patient record and a copy returned to the specialist clinic as detailed above.	
<p>This is to confirm I am agreeing to continue short-term prescribing of FreeStyle Libre® for this patient until confirmation has been received from the next clinic review.</p> <p>PCP name:PCP signature:Date:/...../.....</p>	
<p>This is to confirm that I am <u>NOT</u> willing to accept prescribing responsibility of FreeStyle Libre® for this patient <u>for the following reason:</u></p> <p>.....</p> <p>PCP name: PCP signature:Date:/...../.....</p>	