Insulin Pump Start Orders, English, Canada

PATIENT INFORMATION	
PATIENT'S NAME (FIRST, LAST):	DATE OF BIRTH (YYYY/MM/DD):
HEALTHCARE PROVIDER (HCP):	DATE ORDER REQUESTED (YYYY/MM/DD):

❶ Choose one below:

t:slim X2™ with Control-IQ™ Technology ☐ **On** ☐ Off (Default Control-IQ feature is Off)

OR

t:slim X2™ with Basal-IQ™ Technology ☐ **On** (Default is Basal-IQ feature On) ☐ Off

☐ **Remote video training acceptable**	☐ **Saline Start** (Do not turn on Control-IQ when wearing the pump with saline)

❷ Insulin type: U-100 ☐ Humalog ☐ NovoRapid or ☐ Other insulin (Off label):_____

- ☐ **New to Pump Start** (HCP to complete sections A, B and C below)
- ☐ **Currently on Pump** (Use Current Pump Settings **OR** HCP to complete sections B and C below)
- ☐ **Transitioning from an AID system** (HCP to complete sections B and C below)

A. For MDI insulin start, one option below must be selected (If blank, default protocol will be used)

Default: Take usual dose of long acting insulin	**Per HCP protocol:**
Patient will be instructed to set a temp basal rate to 0% that will end 24 hours after the last injection of long acting insulin and at which time CIQ can be turned on	_____ _____ _____

B. Personal Profile Settings - Enter the Start Time and Dose Settings

Time	Basal Rate (0;0.1-15U/hour)	Correction Factor (0.1 – 33.3 mmol/L)	Carb Ratio (1 – 300 g)	Target BG (single number) (3.9 – 13.9 mmol/L)
Midnight				

C. Enter Desired Amount (If blank, default settings will be used)

Feature/Setting	Default -OR-	Enter Amount
Duration of Insulin Action	5 hours	_____ hours (2-8 hours in 1 min. increments)
Max Bolus	10 U	_____ U (25 U max bolus setting)
Basal Limit	3 U/hour	_____ U/hour (range 0.2-15 U/hour)
Auto-Off	On 12 hours	_____ hours (5-24) or ☐Off

Additional Instructions: _____

_____ Follow-up appointment scheduled with HCP on: _____ (YYYY/MM/DD)

My signature ☐ authorizes ☐ does not authorize the Certified Pump Trainer to make insulin dose adjustments consistent with and not to exceed the parameters set forth in the Healthcare Provider's Instructions for Patient Self-Management form.

HEALTHCARE PROVIDER SIGNATURE	DATE (YYYY/MM/DD):
X	___ ___ ___ ___ / ___ ___ / ___ ___