TANDEM™ Diabetes Care

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www.tandemdiabetes.com

Date: _____

PATIENT'S NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH (MONTH/DAY/YEAR)
	___ ___ /___ ___ /___ ___ ___ ___

Dear _____,

Your patient has been trained on the use of the t:slim® Insulin Pump. Please see the attached t:slim Pump Training Checklist for details and any notes pertaining to this training.

The following insulin pump settings have been programmed per provider's orders or the patient's current pump settings:

Personal Profile (pump settings)				
Time	**Basal Rate**	**Correction Factor**	**Carb Ratio**	**Target BG**
midnight				

Your patient is scheduled to follow-up with your office on _____.

Please feel free to contact me regarding this patient.

Thank you for this referral.

Respectfully,

Tandem Diabetes Care, Inc.