

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN

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Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 3: Insulin Pump Supplement

Effective date: _____

To be completed by physician/provider, diabetes educator and parent/guardian.

Student Name: _____		Date of Birth: _____	
Pump Brand/Model: _____™		Pump Company Technical Assistance Number: _____	
Pump Trainer/Resource Person: _____		Phone/Beeper: _____	
Child-Lock On? <input type="checkbox"/> Yes <input type="checkbox"/> No Code: <u>17</u> (applicable to Cozmo Deltec™ Pump only)			
How long has student worn an insulin pump? _____ or _____			
<input type="checkbox"/> Patient is new to pump therapy and is to initiate use of pump on _____ (date)			

INSULIN / PUMP SETTINGS

<input type="checkbox"/> Rapid-acting Insulin Type: _____® <input type="checkbox"/> Use pump bolus calculator to determine all meal, snack and correction doses unless set or pump malfunction occurs.	Timing of Insulin Dose (Bolus Insulin): Rapid-acting Insulin should always be given prior to <input type="checkbox"/> meals <input type="checkbox"/> snacks if CHO intake can be predetermined. ➤ If CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack. ➤ Treat hypoglycemia before administration of meal or snack insulin.
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Calculating Insulin Doses: According to CHO ratio and Correction Factor (if needed) - the student requires meal time coverage with rapid-acting insulin based on the amount of carbohydrates in meal and may require additional insulin to correct blood glucose to the desired range according to the following formula:

Insulin Dose = [(Actual BG – Target pre-meal BG) divided by Insulin Sensitivity] + [# carbohydrates consumed/CHO Ratio]

- Fractional amounts of insulin from correction and carbohydrate calculation, when added together, may yield an even amount of insulin
- If uneven, then round to the nearest **whole or half unit** (May use clinical discretion; if physical activity follows meal, then may round down).

Target pre-meal BG: _____ mg/dL	Insulin Sensitivity/Correction Factor: <input type="checkbox"/> unit for every _____ > target
CHO Ratio: _____	Exercise/PE CHO Ratio: _____ <input type="checkbox"/> Not Applicable
<input type="checkbox"/> Parent has permission to adjust CHO ratio in a range from 1: _____ to 1: _____	• Less insulin may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

Extra pump supplies to be furnished by parent/guardian: infusion sets reservoirs pods for OmniPod™
 dressings/tape insulin syringes/insulin pen pump manufacturer instructions

STUDENT PUMP SKILLS		Comments/Additional Instructions:
1. Count carbohydrates	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
2. Bolus for carbohydrates consumed	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
3. Calculate and administer correction bolus	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
4. Disconnect pump	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
5. Reconnect pump at infusion set	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
6. Access bolus history on pump	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
7. Prepare reservoir and tubing	<input type="checkbox"/> Independent	
8. Insert infusion set	<input type="checkbox"/> Independent	
9. Use & programming of square/extended/dual/combo bolus features	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
10. Use and programming of temporary basals for exercise and illness	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
11. Give injection with syringe or pen, if needed	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
12. Re-program pump settings if needed	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	
13. Trouble shoot alarms and malfunctions	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance	

School nurses/personnel are not routinely trained on use of specific insulin pumps. School personnel will not perform pump operation without training (to be coordinated with school by caregiver and healthcare provider). If child is not independent and trained RN/personnel are not available, parent/guardian to be contacted for set change. Insulin by injection until set is changed per DMMP orders. If administering via injection, pump must be suspended or disconnected unless ordered otherwise.

Institution Form #

Specific duration of order: 2009-2010 SCHOOL YEAR	Physician/Provider Signature: _____ Provider Printed Name: _____	Office Phone: _____ Office Fax: _____ Emergency # _____
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DIABETES MEDICAL MANAGEMENT PLAN

Part 3: Insulin Pump Supplement (continued)

Student Name:

Effective Date:

HYPOGLYCEMIA MANAGEMENT (Low Blood Glucose):

Follow instructions in DMMP, but in addition:

If seizure or unresponsiveness occurs:

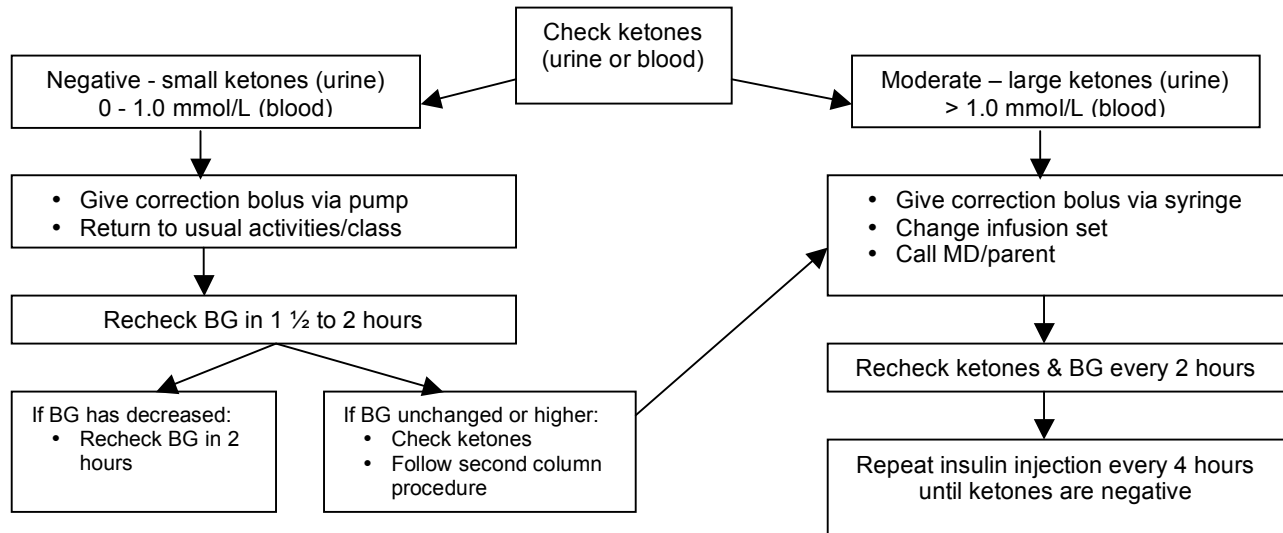
1. **Treat with Glucagon** (See Diabetes Medical Management Plan)
2. **Call 911** (or designate another individual to do so)
3. **Stop insulin pump** by any of the following methods (Send pump with EMS to hospital):
 - Placing in “suspend” or stop mode (See manufacturer’s instructions)
 - Disconnecting at site, pigtail or clip
 - Cutting tubing
4. Notify parent
5. If pump was removed, send with EMS to hospital

HYPERGLYCEMIA MANAGEMENT (High Blood Glucose)

Follow instructions in diabetes medical management plan (DMMP), but in addition:

Prevention of DKA (Diabetic Ketoacidosis)

If Blood Glucose (BG) is >250 mg/dL two times in a row, drink 8-16 oz. of water/hour and follow below:



ADDITIONAL TIMES TO CONTACT PARENT/GUARDIAN

- ◆ Soreness, redness or bleeding at infusion site
- ◆ Leakage of insulin at connection to pump or infusion site
- ◆ Insulin injection given for high BG/ketones
- ◆ Dislodged infusion set
- ◆ Pump malfunction
- ◆ Repeated Alarms

Other Instructions:

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations.

School plan reviewed by:	Physician/Provider Signature:	Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:		Date:
Acknowledged and received by:	School Representative:		Date: