

This form allows access to additional subsidised blood glucose testing strips after the initial six month period provided by the Scheme.

Person with diabetes

1 Given name(s)

2 Family name

3 Date of birth

Day	Month	Year
/	/	

If person with diabetes is under 15 years old, the "Guardian or carer" section must also be completed.

4 Medicare card (preferred) or DVA file number

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5 Optional NDSS card number

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6 Are you of Aboriginal or Torres Strait Islander origin?

Tick all boxes that apply.

No

Yes, Aboriginal

Yes, Torres Strait Islander

7 Can we contact you about research opportunities?

Yes

No

8 By signing here, you are confirming that the information you have provided on this form is true and complete, and that you agree to the collection, use and disclosure of your information for the purposes set out in this form.

 Signed	Dated	/	/
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Guardian or carer

If the person with diabetes is under 15 years old, or is an adult receiving ongoing care, this section must be completed by a primary guardian or carer.

9 Given name(s)

10 Family name

11 By signing here, you are confirming that:

- you are a primary guardian or carer for the person named in Q1 and Q2; and
- the information you and the person with diabetes have provided on this form is true and complete; and
- both you and the person with diabetes agree to the collection, use and disclosure of the provided information for the purposes set out in this form.

 Signed	Dated	/	/
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Lodging this form

Must be certified (on right) by your health professional.

Post: GPO Box 9824 in your capital city

Fax: 1300 536 953

Email: ndss@diabetesaustralia.com.au

In person: NDSS Access Points

Need help with this form?

Call **1300 136 588** or visit ndss.com.au

TTY: 133 677

Speak and Listen: 1300 555 727

Translation: 131 450

Internet Relay: iprelay.com.au

Your information is protected by Commonwealth laws including the *Privacy Act 1988*. Diabetes Australia and our Agents are committed to protecting your privacy. For our privacy policy visit ndss.com.au or call **1300 136 588**.

Certifier

12 Main reason for extension Choose one only.

Inter-current illness (INT)

Medication affecting blood glucose (MED)

Clinical need for self-monitoring (CON)

Diabetes management change (MON)

Diabetes inadequately controlled (MAN)

13 Which are you? Choose one only

CDE Endocrinologist

GP Nurse practitioner

Other registered medical practitioner Describe:

14 Your full contact details

Your name
Medicare provider number/CDE number
Clinic/Hospital name
Address line 1
Address line 2
Suburb
State
Postcode
Phone number
Fax number

15 By signing here, you are confirming the person named in Q1 and Q2 needs additional access to subsidised blood glucose testing strips, for the reason given in Q12.

 Signed	Dated	/	/
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