PATIENT-PROVIDER CONTINUOUS GLUCOSE MONITOR (CGM) AGREEMENT
(This is not an official legal document, but instead an informal agreement)

To Dr. _____

I would like to request a prescription for a continuous glucose monitor (cgm) to help me closely monitor my blood glucose and to help me improve my overall health. I agree to do the following:

- After you place the order to my pharmacy, I will take full responsibility for the use and maintenance of the cgm device
- I will only share my glucose data with you if you are interested. Otherwise I will track my own glucose data and make lifestyle changes accordingly
- For any issues with the cgm device, I will reach out to the cgm vendor website and customer support line. I understand you may not be familiar with cgm troubleshooting issues, so I will not be contacting you or your staff for problems with the cgm
- I understand there can be some risks with using the cgm device. This may include, but not be limited to the following:
  -Bleeding or infection at the sensor insertion site
  -Skin reactions: rash, itchiness, pain, bruising
  -Muscle soreness at insertion site
  -Inaccurate data (very high blood glucose or very low blood glucose) which can lead to incorrect and unnecessary interventions and actions. I will be using an additional fingerstick glucose monitor to confirm any extreme and unexpected readings
  -Excessive anxiety and stress over glucose readings that are out of range
  -Sleep disturbances due to sensor location

I appreciate you supporting my use of a cgm to help manage my lifestyle and overall health.

_____	_____
Patient Name (Print)	Provider Name (Print)
_____	_____
Patient Signature	Provider Signature
_____	_____
Date	Date