

**METER EXEMPTION FORM – To be completed by Diabetes Specialist Nurses in Secondary Care or in the Community**

Patient Name:

DOB:

Date:

# Recommended meter for this patient

1. Name of meter:

............................................................................................................................

|  |  |  |  |
| --- | --- | --- | --- |
| Product | Type | Number | Frequency |
| Glucose strips |  |  |  |
| Lancets |  |  |  |
| Ketone strips (capillary) |  |  |  |

1. None of the formulary meters are suitable because:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

…………………………………………………………………………………………………

1. Meter prescribed by: (please print)

……………………………………………………………………………………………. Job description:

…………………………………………………………………………………………….

**To the practice:**

Please scan this form into the patient’s notes. Thank you.

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