

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

## Your details

**1 Given name(s)**

**2 Family name**

**3 Date of birth**

Day	Month	Year
/	/	

If person named in Q1 & Q2 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 NDSS card number (Optional)**

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**6 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 named in Q1 & Q2 is under 15 years old, or is an adult receiving ongoing care, this section must be completed by a primary guardian or carer.

**7 Given name(s)**

**8 Family name**

**9 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 named in Q1 & Q2 have provided is true and complete; and
- both you and the person named in Q1 & Q2 agree to the collection, use and disclosure of your information for the purposes set out in this form.

	Signed	Dated	/	/
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**Lodge this form in person  
at your local  
NDSS access point**

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](http://ndss.com.au) or call **1300 136 588**.

## Certifier

Only to be completed by a registered medical practitioner, nurse practitioner, or credentialed diabetes educator (CDE).

**10 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 management not stable  (MAN)

**11 Which are you? (Choose one only):**

- CDE  Endocrinologist
- GP  Nurse practitioner

Other registered medical practitioner  Describe:

**12 Your full contact details OK to use stamp**

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

**13 By signing here, you are confirming the person named in Q1 and Q2 needs additional access to subsidised blood glucose test strips, for the reason given in Q10.**

	Signed	Dated	/	/
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**Need help with this form?**

Call **1300 136 588** or visit [ndss.com.au](http://ndss.com.au)

TTY: 133 677

**Speak and Listen:** 1300 555 727

**Translation:** 131 450

**Internet Relay:** [internet-relay.nrscall.gov.au](mailto:internet-relay.nrscall.gov.au)