Dexcom Audit: Follow-up Form

This form is only for individuals using standalone CGM; for individuals using closed-loop please complete the commercial closed-loop or DIY APS audit forms

Patient identifiable information in this section will be encrypted to ensure anonymity and only accessible to the submitting centre

Name

NHS Number

Date of Birth

Weight kg OR st/lb

Follow-up date:

Is the individual still using a Dexcom sensor?
Yes ☐ No ☐ → if stopped please complete box with reason

Has the individual changed which sensor they are using?
Yes ☐ No ☐

If yes, which sensor is now being used?
Dexcom One ☐ Dexcom One+ ☐ G6 ☐ G7 ☐

Reason for stopping (select all that apply)
Skin site reactions ☐
Alarm fatigue ☐
Concerns over accuracy ☐
Healthcare professional decision ☐
Switch to alternative sensor ☐
Switch to closed-loop ☐
Body image concerns ☐
Stigma ☐
Other

If using insulin, what type of therapy is this? *If now using closed-loop please do not enter data into this tool – use the DIY or closed-loop audit tools instead as appropriate*
Basal only ☐ Mealtime only ☐ BD Pre-mixed ☐ Basal-bolus ☐ Pump alone ☐
Other (please provide details)

Is this person using connected insulin pens?
Yes ☐ No ☐

Other non-insulin diabetes medications (if applicable)
None ☐ Metformin ☐ Sulphonylurea ☐ Pioglitazone ☐ DPP4i ☐
SGLT2i ☐ GLP1RA ☐ Other (please detail)

Healthcare utilisation (please complete in retrospect for the 12 months prior to commencing Dexcom)

	Hyperglycaemia/DKA	Hypoglycaemia	Other (diabetes)	Other
No of hospital admissions				
Dates				
No of paramedic callouts (not resulting in admission)				
Dates				

Number of hypoglycaemic episodes requiring third party assistance but not paramedic call outs
Don't know ☐
Dates

Gold Score (prior to Dexcom use, DO NOT enter recollected information, only record if previously documented or if this form is being completed prior to commencement) ADULT USERS ONLY

Ask the person: Do you know when your hypos are commencing?
1=always, 7=never

1 2 3 4 5 6 7

Diabetes distress scale (DO NOT enter recollected information, only record if previously documented or this form is being completed before commencement)
ADULT USERS ONLY

Question	Not a problem	A slight problem	A moderate problem	A somewhat serious problem	A serious problem	A very serious problem
1. Feeling overwhelmed by the demands of living with diabetes	1	2	3	4	5	6
2. Feeling that I am failing with my diabetes routine	1	2	3	4	5	6

HbA1c (since commencing Dexcom)

	Dates	Values (mmol/mol)
Lab HbA1c		

Sensor data (*last 14 days)*

Time >13.9mmol/L (%)	
Time 10.1-13.9mmol/L (%)	
Time 3.9-10mmol/L (%)	
Time 3-3.8mmol/L (%)	
Time <3mmol/L (%)	
Coefficient of variation (%)	
GMI (14 days)	

User/Caregiver opinion of Dexcom

Would they recommend Dexcom sensors to other people with diabetes?

Not recommend at all — Recommend extremely highly

1 2 3 4 5 6 7

What Impact would they rate Dexcom has had on their quality of life?

Extremely negative impact — Extremely positive impact

1 2 3 4 5 6 7

Do you prefer Dexcom to your previous method of blood glucose monitoring

Strongly dislike — Strongly prefer

1 2 3 4 5 6 7

User/Caregiver comments

This box can be used for any additional comments. Please do not include patient identifiable information.

Healthcare professional comments

This box can be used for any additional comments. Please do not include patient identifiable information.