Youth Diabetes Action
兒童糖尿協會

Jockey Club Support for Young People with Diabetes
賽馬會年輕糖尿支援計劃申請表格

Introduction 簡介

Good diabetes management requires self-monitoring of blood glucose multiple times a day. Before Continuous Glucose Monitor (CGM), regular finger-prick test was the only way to monitor glucose level. To help ease the pain and improve life with diabetes, and thanks to the sponsorship of the Jockey Club Charities Trust, Youth Diabetes Action will provide free CGMs for 2 years to selected children and youth with diabetes aged 2 to 30.

良好的糖尿病管理依靠每日多次的血糖測試，在連續血糖監測儀（CGM）面世前，患者只能使用手指刺針方式（俗稱「篤手指」）量度血糖。感謝賽馬會慈善信託基金的資助，兒童糖尿協會將為 2 至 30 歲糖尿病患者提供兩年用量的 CGM，讓他們得到全天候血糖監察，提高生活質素。

Eligibility 資格

- Diabetes patients aged 2-30
  2 至 30 歲的糖尿病患者
- Hong Kong permanent residents
  香港永久居民
- Diabetes patients aged below 2 or above 30 with financial or diabetes management difficulties, or pregnancy
  2 歲以下或 30 歲以上，有財政或糖尿病管理困難或懷孕的糖尿病患者

Methods of application 申請辦法

Complete application form and consent form together with supporting documents and post, fax or email to YDA.
申請人須填妥此表格及同意書，並連同相關證明文件，郵寄、傳真或電郵至本會。

- Mailing address: Room 1607, Clifford Centre, 778-784 Cheung Sha Wan Road, Lai Chi Kok, Kowloon
  郵寄地址：九龍長沙灣長沙灣道 778-784 香港中心 1607 室
- E-mail 電郵：SupportDM@yda.org.hk
- Fax 傳真：2544 3711

Format of subsidy 資助形式

Successful applicants will receive 2 years supply of CGM.
成功申請者將獲得兩年用量的連續血糖監測儀。

Enquiries 查詢

For enquiries, please contact Youth Diabetes Action Staff.
如有任何查詢，請與本會負責同事聯絡。

李小姐 (Wing Ki Lee) Email: wklee@yda.org.hk Tel: 2544 3833

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Part I - Particulars of applicant 第一部份 — 申請人資料

Name 姓名 (English) Surname _____ Given Name _____ (中) _____

Gender 性別 Male 男 / Female 女

Date of Birth (dd/mm/yyyy) 出生日期 (日/月/年) ____/____/____

Membership No. 會員號碼 _____

Type of Diabetes 糖尿病類型 Type 1 一型 / Type 2 二型/Others 其他

Follow Up Hospital 覆診醫院 _____

Year and month of Diagnosis 確診年份及月份 _____

Other Medical condition(s) (if any) 其他疾病（如有） _____

Email 電郵 _____

Telephone 電話 _____

Brand & model of Mobile Phone 智能電話牌子及型號 _____

Address 地址 _____

Please"✓" for type(s) of allowance received (if any) 請在已獲取的援助 / 津貼內打「✓」（如有）

☐ Applicant is currently a beneficiary of the YDA Financial Assistance Programme
申請人現正受惠於兒童糖尿協會醫療用品資助計劃（FAP）

☐ Applicant is currently a beneficiary of the Comprehensive Social Security Assistance (CSSA) Scheme
申請人現正領取綜合社會保障援助（綜援）計劃

Part II – Details of parents or emergency contact 第二部份 — 家長或緊急聯絡人資料

Contact 1 第一位聯絡人			
Name 姓名		Relationship 關係	
Email 電郵		Contact number 聯絡電話	
Contact 2 第二位聯絡人			
Name 姓名		Relationship 關係	
Email 電郵		Contact number 聯絡電話	

Part III - Current CGM Consumptions# 第三部份 — CGM 使用現況#

Have you used CGM before? 曾否使用 CGM？			☐ Yes 是 ☐ No 否
Are you currently getting CGM from Hospital Authority? * 你現在是否從醫院管理局獲得 CGM？*			☐ Yes 是 ☐ No 否
Continuing from the above question, if yes, how many you get in the past 12 months? 承上題，如有，過去 12 個月共取得多少個 CGM？			
Brand of CGM currently using 現使用之 CGM 品牌	☐ Dexcom	☐ FreeStyle Libre	☐ Medtronic
Brand and model of real-time CGM applied for # 欲申請之實時 CGM 品牌及型號#	☐ Dexcom - G7	☐ Freestyle Libre 2 Plus	☐ Medtronic – Guardian 3 ☐ Medtronic – Guardian 4 ☐ Medtronic – Simplera
	☐ Other real time CGM brands 其他實時 CGM 牌子及型號：_____		

YDA reserves the right to allocate the brand and quantity of CGM to successful applicants. Applicants cannot arbitrarily request to change the approved CGM model, unless the applicant has reasonable grounds and obtains a referral form signed by a healthcare professional. YDA 保留分配 CGM 的數量、品牌及型號的決定權。申請人不能任意要求更換獲批之 CGM 品牌及型號，除非申請人有合理理由並取得由醫護人員簽發之轉介表

* The quantity of CGM distributed under the Jockey Club Support for Young People with Diabetes' programme is complementary to match the CGM programme of the Hospital Authority 賽馬會年輕糖尿支援計劃派發的 CGM 數量將配合醫院管理局 CGM 計劃

Part IV - Supplementary Information 第四部份 — 補充資料

Are you planning to study or stay abroad for longer than 3 months during project period?
是否打算在計劃期內留學或逗留海外超過 3 個月？

□ Yes 是（Please specify place and period of stay. 請註明地點及逗留時間 。） □ No 否

_____

Other information 其他補充事項
e.g. Pregnancy, Special medical needs, relatively higher HbA1c, financial difficulty or other information
如懷孕、特殊醫療需要、糖化血色素偏高、經濟困難或其他補充事項

Notes 附註

a. CGM supply will be on a first-come-first-served basis. 名額有限，先到先得，額滿即止。
b. YDA reserves the right to amend the terms or cancel this Programme at its discretion without any notice. 本會有權更改或取消本計劃而毋須作出任何通知及解釋
c. If an excess supply of CGM sensors is given due to miscalculation, applicants are liable to return any excess quantity to YDA. 倘若因計算錯誤而導致申請人獲多發放物資，申請人必須把物資退還
d. All CGM distributed by YDA are not to be used for commercial or resale purposes. 所有兒童糖尿協會派發的連續血糖監測儀均不可用作商業或轉售用途。
e. Selected users must consult their own attending medical professionals regarding CGM data or alerts. YDA will not be responsible for any medical data or alerts by CGMs provided to users. 獲選申請人需自行向主診醫護查詢任何與連續血糖監測儀有關的數據或警示。兒童糖尿協會恕不為所提供的連續血糖監測儀的任何醫學數據或警示負責。
f. Allergy or bleeding may occur on the applied site of CGM, users must assume the risks themselves. 使用連續血糖監測儀之位置有機會出現敏感或流血等情況，用家需自行承擔風險。
g. The information collected in the Jockey Club Support for Young People with Diabetes Programme is only used for programme application, approval, research and programme related purposes. At the end of the programme, the above-mentioned information will be destroyed. 賽馬會年輕糖尿支援計劃中收集的資訊僅作計劃申請、審批、研究及其他相關之計劃用途。計劃完結時，上述有關資料將被銷毀。

Declaration 聲明

I certify that the information provided is true and complete. 本人證明以上所提供的資料屬實，正確無誤。

If participant is **below 18 years old**, please sign by parent/guardian. 如參加者未滿 18 歲，請由家長/監護人簽署。

Signature of parent/guardian
家長/監護人簽署：_____

Name of parent/guardian
家長/監護人姓名：_____ Date 日期：_____

If participant is **aged 18 or above**, please sign below. 如參加者年滿 18 歲，請於下列簽署。

Signature of participant
參加者簽署：_____

Name of participant
參加者姓名：_____ Date 日期：_____

Appendix I - Consent Form

附件一同意書

Name of participant
參加者姓名：_____ Membership no.
會員編號：_____

I understand and agree myself / my child to participate in this programme, and agree to the following terms of the Jockey Club Support for Young People with Diabetes Project:
我明白和同意下列賽馬會年輕糖尿支援計劃的條款，並同意本人/ 本人子女參加該計劃：

1. Allergy or bleeding may occur on the applied site of CGM
   明白使用連續血糖監測儀之位置有機會出現敏感或流血等情況
2. I shall make good use of the given CGMs, otherwise I shall return the remaining unused CGMs to the Youth Diabetes Action.
   同意善用獲贈之連續血糖監測儀，否則會把餘下數量交還到兒童糖尿協會
3. I agree that all CGM distributed by YDA are not to be used for commercial or resale purposes.
   同意所有兒童糖尿協會派發的連續血糖監測儀均不可用作商業或轉售用途
4. I understand and agree to participate in surveys conducted by the Faculty of Medicine, The Chinese University of Hong Kong, for evaluating the benefits of the CGM
   參與香港中文大學醫學院所主導的連續血糖監測儀效益評估調查
5. For the evaluation of the benefits of the usage of CGM, I agree that staff of YDA and delegated members of the study team of the Faculty of Medicine, The Chinese University of Hong Kong can access my/ my child's CGM glucose data and relevant medical information for purposes of evaluating the effectiveness of CGM
   授權兒童糖尿協會職員及香港中文大學醫學院糖尿病研究人員，取得本人或本人子女的連續血糖監測儀的血糖數據及醫療資訊以評估使用連續血糖監測儀的效益
6. Understand that Youth Diabetes Action is only responsible for the distribution of CGM. In case of technical issues with the CGM and other related tools or mobile applications, I will inquire with the manufacturer or supplier of the CGM
   明白兒童糖尿協會只為連續血糖監測儀的派發單位，如遇連續血糖監測儀及其他有關工具或智能電話應用程式的技術問題，將向連續血糖監測儀的生產商或供應商查詢
7. Commitment of selected users 申請人承諾：
   - Learn and follow the instructions for proper use of CGM to improve diabetes management
     學習使用連續血糖監測儀以改善管理糖尿病
   - Attend CGM installation and training sessions by YDA
     出席 YDA 舉辦的連續血糖監測儀相關培訓課程
   - Attend HbA1c testing at YDA at the beginning, 6th, 12th and 24th month of the 2-year period of receipt of CGM, or submit proof from hospital
     在計劃開始、計劃的第 6、第 12 及第 24 個月到 YDA 進行糖化血紅素檢查，或提交醫院的報告

By signing below, I understand and agree to the above terms and agree the aforementioned participant to join this programme.
以下簽署，表示我明白及同意以上條款，並同意上列參與者參加該計劃。

If participant is **below 18 years old**, parent/guardian please sign the consent form:
如參加者未滿 18 歲，請由家長/監護人簽署。

Signature of parent/guardian
家長/監護人簽署：_____

Name of parent/guardian
家長/監護人姓名：_____ Date
日期：_____

If participant is **aged 18 or above**, please sign below:
如參加者年滿 18 歲，請於下列簽署。

Signature of participant
參加者簽署：_____

Name of participant
參加者姓名：_____ Date
日期：_____

Documents Checklist 所需文件清單

Please check if the required documents are attached 請檢查所需文件是否齊備	Applicant check 申請人專用	YDA check YDA 專用
Appendix I 附件一 - Consent form 同意書		
- Applicant's medical proof (e.g. copy of previous HbA1c record, consultation appointment slips) 申請人之醫療證明（如過去糖化血紅素的報告、醫院覆診紙之副本）		
Supporting documents (for age above 30 only) (if applicable) 證明文件 (只限 30 歲以上申請者) （如適用）		
- Applicant's medical proof (e.g. copy of previous HbA1c record, consultation appointment slips, medical record of other chronic diseases) 申請人之醫療證明（如過去糖化血紅素的報告、醫院覆診紙之副本、其他長期病的醫療記錄等之副本）		
- Applicant's proof of pregnancy, if applicable (e.g. copy of consultation appointment slips) 申請人的懷孕證明（如適用）（例如醫院覆診紙之副本）		
- Applicant with financial difficulty: Proof of income for applicants (e.g. copy of salary statement, tax return forms of the last 12 months, or income declaration form) 有經濟困難的申請人之收入證明（如過去 12 個月期間的糧單、税單等之副本或收入聲明書）		

YDA Office use only 只供 YDA 內部使用	
Result 審核結果	Approved 接納 / Not approved 未能批准
Approved model 批核型號	
Approved quantity 批核數量	
Approval due date 獲批期限	
Approved by 審批同事	
Approval date 批核日期	
First batch of CGM pick up date 首次領取 CGM 領取日期	

To be filled out by medical professionals from public hospitals/clinics, specialists in endocrinology 此部份由公立醫院或診所醫護人員, 或內分泌科專科醫生填寫

Appendix II Referral Form for change of CGM brand 附件二：轉換 CGM 牌子轉介表

Name of Applicant 申請人姓名：_____ Age 年齡：_____

Contact number of Applicant 申請人聯絡電話：_____

✓ Please tick the appropriate box 請剔選適當的方格

1. Which real-time CGM brand is most suitable for the applicant?
   申請人適用的實時連續血糖監測儀品牌及型號

☐ Dexcom – G7	☐ Freestyle Libre 2 Plus	☐ Medtronic – Guardian 3 ☐ Medtronic – Guardian 4 ☐ Medtronic – Simplera
☐ Other real time CGM brands & model 其他實時 CGM 牌子及型號：_____		

Signature of medical professional 醫護人員簽署：_____ Hospital/ Specialist Clinic 醫院/專科診所：_____

Name 姓名：_____ Date 日期：_____