// PATIENT ENROLMENT, RX & CONSENT FORM

Fax must be sent directly from physician office

Please Fax to Pharmacy: **BAYSHORE SPECIALTY RX LTD.** upon completion at **1-855-438-2314.**

PATIENT Information *Required

*FIRST NAME:	MIDDLE NAME:	*LAST NAME:
*EMAIL:		
*TEL.: (HOME)	(MOBILE)	(WORK)

BEST TIME TO BE REACHED: ☐ 8AM - 12PM ☐ 12PM - 6PM ☐ 6PM - 9PM

*PREFERRED LANGUAGE: ENGLISH ☐ FRENCH ☐

*ADDRESS:

OFFICE Information For Office Use Only

*PRESCRIBER NAME:

*TEL.: (OFFICE)

OFFICE ADDRESS:

PRESCRIBING SECTION

Please ☑ and complete the required information below.

☐ FreeStyle Libre **STARTER PACK**

For patients who are using FreeStyle Libre for the first time. The FreeStyle Libre starter pack includes:

// 1 FreeStyle Libre reader

// 2 FreeStyle Libre sensors (2 sensors/28 days)

☐ **Refill** FreeStyle Libre **SENSOR**

For patients on FreeStyle Libre who need additional FreeStyle Libre sensors

_____ sensors Repeat _____ times

26 sensors = 12 months supply

Prescriber certification: I certify that this prescription is an original prescription and this pharmacy is the only receiver. The original will not be reused.

*PRESCRIBER SIGNATURE:	COLLEGE LICENCE #:	*DATE: (DD/MM/YYYY): ___ /___ /_____

PATIENT CONSENT

SEE FULL PATIENT CONSENT AND PRIVACY INFORMATION ON BACK PAGE.
PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND THIS INFORMATION.

My signature below confirms that I have read and understand the patient consent and privacy information and agree to the collection, use and disclosure of my personal information in accordance with those terms.

*PATIENT SIGNATURE:	*DATE: (DD/MM/YYYY): ___ /___ /_____

FOR PATIENT TO KEEP

Your healthcare professional has sent your FreeStyle Libre System prescription to Bayshore Specialty Rx LTD., here is what to expect:

1. You will receive a call from 'Bayshore Specialty Rx LTD.' to complete a registration **OR** you may go to https://libre.myfreestyle.ca/create-account to register online.

2. Please have the following information regarding your insurance (and any other insurance you are covered under, i.e. spouse or parent) ready when contacted by Bayshore:

Name of Insured: _____

Relationship to insurance card holder: _____

Name of Patient: _____ Patient's DOB: (DD/MM/YYYY) ___/___/_____

Insurance Company: _____ Group/Plan/Policy #/ID: _____

Member ID: _____

If you are not currently eligible for insurance coverage and would like to order the FreeStyle Libre system, please visit MyFreeStyle.ca

3. Bayshore will contact you if there is a remaining balance after your insurance coverage.

Abbott

PATIENT CONSENT – For New Patients Only

I agree to permit my healthcare provider(s), including physician(s) or nurse(s), to disclose to Bayshore Specialty Rx my personal information in order to facilitate my obtainment of FreeStyle Libre and to provide me with additional information on FreeStyle Libre. I understand this is not an order form for FreeStyle Libre but is rather a consent form for me to be contacted by Bayshore Specialty Rx with further information on the product. I agree to Bayshore Specialty Rx contacting me for such purposes. I also agree that Bayshore Specialty Rx may share my personal information collected from me or from my health care provider(s) with public (government) or private insurers for purposes relating to reimbursement or fulfillment of products orders. Personal information may include my name, medical condition, address and phone number included on this Patient Consent Form (the "Consent Form") or on my prescription (if applicable). For more information on Bayshore Specialty Rx's privacy policy and practices, please submit a written request to: 2101 Hadwen Road, Mississauga, Ontario, L5K 2L3.

My personal information will not be used or disclosed by Bayshore Specialty Rx for any purpose other than those described above unless information that identifies me directly is first removed or as is permitted or required by law.

I understand and agree that:

- I do not have to sign this Consent Form, but if I do not, my healthcare providers will not be able to disclose my personal information to Bayshore Specialty Rx and I will not be able to benefit from the services provided by Bayshore Specialty Rx (unless I contact Bayshore Specialty Rx directly myself);
- If I provided my email address on this Consent Form, Bayshore Specialty Rx send me communications by email for purposes related to reimbursement or fulfillment of product orders. My email address may not be used for other purposes;
- I may request access to my personal information, correct any errors in that information or revoke (take back) my consent at any time by mailing or faxing signed letter(s) of access, correction or revocation to Bayshore Specialty Rx's address above, but if I revoke my consent, I may be unable to benefit from the services provided by Bayshore Specialty Rx;
- I am entitled to a copy of this Consent Form;
- My personal information will primarily be stored within Canada; however, in the event that it is stored and processed outside of Canada, I acknowledge that my personal information will be subject to the laws of that country that may be different than in Canada;
- My personal information may be shared with third-party service providers on a need-to-know basis and solely for supporting the purposes set out above, in accordance with this Consent Form and Bayshore Specialty Rx's privacy policy and practices.
- My personal information may be shared with health care providers, insurers or third-party service providers of Bayshore Specialty Rx on a need-to-know basis and solely for supporting the purposes set out above, in accordance with this Consent Form and Bayshore Specialty Rx's privacy policy and practices.