## Measure Your Readiness

The questions below will help you and your health care professional assess your readiness for pumping. Place any extra notes after the last question.

### Motivation

1. On a 1 to 7 scale, how interested are you in using a pump?
   not interested 1 2 3 4 5 6 7 very interested
2. How motivated are you to control your glucose levels?
   not motivated 1 2 3 4 5 6 7 very motivated
3. Are you willing to check your glucose more often, and keep/download glucose records?
   ❑ yes ❑ no ❑ maybe
4. How likely do you believe you can control your glucoses day-to-day?
   not likely 1 2 3 4 5 6 7 very likely
5. How convenient will a pump be in your daily life?
   not convenient 1 2 3 4 5 6 7 convenient
6. Will better glucose control improve your health?
   not likely 1 2 3 4 5 6 7 very likely
7. How comfortable are you about having diabetes – discussing it with friends, checking glucose in front of others, using an insulin pen or syringe in public?
   not comfortable 1 2 3 4 5 6 7 very comfortable
8. Will others accept you if you wear a pump?
   not likely 1 2 3 4 5 6 7 very likely
9. How excited are you about adapting new technology to control your diabetes?
   not excited 1 2 3 4 5 6 7 very excited
10. Have you considered, or discussed with others, situations that might make wearing a pump inconvenient, such as athletics, work environment, etc.?
    ❑ yes ❑ no ❑ not yet Which situations may present problems?

    _____
11. Who can you rely on for support if pump problems arise?

    _____

### Need

1. How close is your most recent A1c or average glucose level to your goal?
   not close 1 2 3 4 5 6 7 very close ❑ Don't know
2. Are frequent highs or lows a problem?
   ❑ yes ❑ no ❑ sometimes
3. Have your lows been severe – ER visit, need other's help, hypoglycemia unawareness?
   ❑ yes ❑ no ❑ rarely
4. Do you have night lows or frequent morning highs?
   ❑ yes ❑ no
5. Do you use less than 40 units of insulin a day and need precise insulin doses?
   ❑ yes ❑ no
6. Do you travel frequently, have a varied school schedule, or work split shifts?
   ❑ yes ❑ no

7. Do you live alone and need safety features like BOB tracking, Auto-Off where the pump shuts off automatically, basal suspend for hypoglycemia with a CGM?
   ❑ yes ❑ no

**Preparation**

1. Number of insulin injections per day:
   0 1 2 3 4 5+
2. Number of glucose tests you do each day:
   0 1 2 3 4 5+
3. Do you write down or download your glucose test results?
   ❑ yes ❑ no ❑ occasionally
4. Do you currently adjust your rapid-acting insulin for the carbs in snacks and meals?
   ❑ yes ❑ no
5. Do you currently give extra insulin to correct high glucoses?
   ❑ yes ❑ no
6. Do you adjust your long-acting insulin doses?
   ❑ yes ❑ no
7. Do you use carb counting or other method to match a meal with a meal dose?
   ❑ yes ❑ no ❑ sometimes
8. Do you regularly review your glucose data to improve your readings?
   ❑ yes ❑ no ❑ rarely
9. Do you adjust insulin doses or foods eaten to improve your glucose results?
   ❑ yes ❑ no ❑ occasionally

**Other Considerations**

1. Do you have vision problems or arthritis where a specific pump may help enter selections, fill the reservoir, or insert an infusion set?

   _____

2. Will your health insurance company, HMO, or Medicare cover the cost of pump therapy? Will out-of-pocket expenses fit your budget?

   _____

**Questions for Parents to Consider**

1. How willing is your child or teen to wear a pump?
   not willing 1 2 3 4 5 6 7 very willing ❑ too young to decide
2. How willing are you to be involved in your child/teen's pump program?
   not willing 1 2 3 4 5 6 7 very willing
3. Will your child try to hide their pump/diabetes from their peers?
   ❑ yes ❑ no ❑ unsure
4. Does your child/teen learn new skills easily?
   ❑ yes ❑ no ❑ sometimes
5. Does your child/teen give their own injections, count carbs, determine their own doses, and monitor glucose levels with minimal help?
   ❑ yes ❑ no ❑ not yet
6. How do you feel about your child/teen gradually assuming age-appropriate responsibility for their own diabetes care?

7. Will you have a trained diabetes professional available when you need help?
   ❑ yes ❑ no ❑ unsure

## Notes