

**[NOTE TO Health Care Provider OR CLINIC:** By using this SAMPLE consent form, you agree to (i) review and make any revisions that you deem appropriate, prior to adopting or incorporating this form into your practice, and (ii) to take full responsibility over the content and utilization of the consent form with respect to your patients.]

## **Patient Consent Form Eversense® Sensor Insertion/Removal Procedure**

[Insert Office/Practice Name, Address, Telephone]

**To the Patient: By reviewing and signing this Consent Form, you are agreeing to receive or undergo the medical procedure described below. Before you provide consent, you have the right to be fully informed about this procedure, including any risks, hazards, and/or side effects involved. Please do not hesitate to discuss the procedure and any questions you may have with your health care provider and his/her staff.**

By my signature below, I consent to the medical procedure described below to be performed by my health care provider (or another health care provider designated by my physician), along with assistance from his/her clinical staff, to be performed at the above location. The medical procedure will involve the insertion of an **Eversense® Continuous Glucose Monitoring (CGM) sensor** (“**Eversense Sensor**”), and/or the removal of a previously-inserted Eversense Sensor. The procedure, as well as the Eversense CGM System, has been explained to me completely in terms that I understand.

Specifically, I understand the procedure involves making a small incision (approximately 5-6 mm in width) in my upper arm under local anesthesia, followed by an insertion/removal of the Eversense Sensor. The incision will be closed with steri-strips and possibly sutures, depending on my healthcare provider’s assessment. The closed incision will be covered with a sterile bandage. General risks include possible pain, scarring, bleeding, and/or infection, and any related or consequential conditions or issues. I understand the insertion site will need to stay covered and dry for at least 48 hours after the procedure, and that I will follow the incision care instructions provided by my health care provider.

I understand that I am free to consult with other health care providers about this procedure, and I can refuse any medical treatment at any time prior to its performance. I am aware that the practice of medicine is not an exact science, and that no guarantees have been made regarding the results of this procedure. (If applicable, I authorize: (i) a health care provider -in-training to participate in my care; (ii) a representative or technician from a medical device company to be present at the procedure (for education or assistance); and (iii) medical photography to be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in any way.)

I have read (or had read to me) and fully understand the above information, and consent to the procedure as described above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Name of Patient Representative: \_\_\_\_\_ (if signed for Patient above)

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Name: \_\_\_\_\_

I have explained the information contained in this document to the patient (and/or authorized patient representative). It is my opinion that the person granting consent has fully understood all subjects discussed.

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Name