

**INSULIN INJECTION TECHNIQUE COMPETENCY DOCUMENT**

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

Patient Number: \_\_\_\_\_

Assessors Name: \_\_\_\_\_

Assessors Signature \_\_\_\_\_

**NOT COMPETENT**

**COMPETENT**

**1**

**2**

**3**

**4**

**5**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>DIALS PEN DEVICE</b>					
<b>PERFORMS AIR SHOT</b>					
<b>IDENTIFIES SUITABLE INJECTION SITES</b>					
<b>INJECTS CORRECTLY</b>					
<b>CORRECT HYGIENE PROCEDURES</b>					
<b>SAFE STORAGE OF INSULIN</b>					
<b>PATIENT/CARER CONFIDENT IN INJECTING INSULIN</b>					