Diabetes Prevention Program

Location: ____

A Lifestyle Change Program

PATIENT INFORMATION	
First Name	Address
Last Name	
Health Insurance	City
Gender ☐Male ☐Female	State
Birthdate	Zip Code
Email	Phone

By providing your information above, you authorize your health care provider to provide this information to a diabetes prevention program provider, who may in turn use this information to communicate with you regarding its diabetes prevention program.

PRACTITIONER INFORMATION	
Physician/NP/PA	Address
Practice Contact	City
Phone	State
Fax	Zip Code

SCREENING INFORMATION

Body Mass Index	Eligibility ≥ 25 kg/m^2 * (≥23 kg/m^2 if Asian)	
Blood Test (report one)	Eligible Range	Test Results (report one)
--Hemoglobin A1C	5.7-6.4%	____________________
--Fasting Plasma Glucose	100-125 mg/dL (Medicare 110-125 mg/dL)	____________________
--2-hour Plasma Glucose (75 gm OGTT)	140-199 mg/dL	____________________
Date of blood test (mm/dd/yy):		

History of gestational diabetes mellitus: ☐ Yes ☐ No

Score of 5 or higher on ADA Prediabetes Risk Assessment: ☐ Yes ☐ No

For Medicare requirements, I will maintain this signed original document in the patient's medical record.

Date: Practitioner signature:

By signing this form, I authorize my physician to disclose my diabetes screening results to the___________________________________ DPP for the purpose of determining my eligibility for the diabetes prevention program and conducting other activities as permitted by law.

I understand that I am not obligated to participate in this diabetes screening program and that this authorization is voluntary.

I understand that I may revoke this authorization at any time by notifying my physician in writing.

Any revocation will not have an effect on actions taken before my physician received my written revocation.

Date: Patient signature:

IMPORTANT WARNING: The documents accompanying this transmission contain confidential health information protected from unauthorized use or disclosure except as permitted by law. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted to do so by law or regulation. If you are not the intended recipient and have received this information in error, please notify the sender immediately for the return or destruction of these documents. Rev. 10/6/17

This document was adapted from the Prevent Diabetes STAT Toolkit patient referral form.

*The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility.