Referral to a Diabetes Prevention Program

PATIENT INFORMATION			
First Name			**Address**
Last Name			
Health Insurance			**City**
Gender			**State**
Birth Date (mm/dd/yy)	**Age** (must be ≥18)		**ZIP code**
Email			**Phone**

SCREENING INFORMATION	ELIGIBILITY	TEST RESULT	DATE (mm/dd/yy)
Body Mass Index (BMI)	≥25 (≥23 if Asian)		
Blood Test (at least one)			
Hemoglobin AIC	5.7-6.4%		
Fasting Plasma Glucose	100-125 mg/dl		
2-hour plasma glucose (75 gm OGTT)	140-199 mg/dl		
Gestational Diabetes	Self-report must = YES		

PRACTITIONER INFORMATION	
Provider Name	**Address**
Practice Contact	**City**
Phone	**State**
Fax	**ZIP code**

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 primary care provider to disclose my diabetes screening results to the Diabetes Prevention Program of my choice for the purpose of determining my eligibility for the program and conducting other activities as permitted by law. **I understand** that I am not obligated to participate in this diabetes prevention program and that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying my primary care provider in writing. Any revocation will not have an effect on actions taken before my primary care provider received my written revocation.

Date_____ **Patient Signature** _____

Please fax this referral to the program provider of my choice: (Check one)

DPP ORGANIZATION	FAX #	SERVICE AREA
___Caroline County Health Department	410-479-2014	Caroline
___Eastern Shore Wellness Solutions	410-221-8851	Dorchester
___Kent County Health Department	410-778-6882	Kent