New York State Diabetes Prevention Program (NYS DPP) Patient Recommendation

The New York State Diabetes Prevention Program is an evidence-based program for adults with diagnosed prediabetes or who are at high risk for developing type 2 diabetes. The program is led by a trained Lifestyle Coach and meets one hour per week for 16 weeks, followed by at least six monthly follow-up sessions. The program is delivered in community or health care settings, in groups of 10-15 people, where personal lifestyle goals are set by each participant. The sessions cover healthy eating, physical activity, and lifestyle changes to help participants achieve the goals that lead to the prevention or delay of a diabetes diagnosis, including a 5-7% weight loss and maintenance, and a gradual increase in physical activity to 150 minutes per week.

Patient Information

Name_____ Date of Birth_____

Address _____

City _____ State _____ Zip_____

Primary Phone Number _____ Secondary Phone Number _____

E-mail Address_____ Gender ☐ Female ☐ Male

I (print name), _____ , have read the AUTHORIZATION TO RELEASE HEALTH INFORMATION on the back of this form and give my health care provider permission to send my information directly to the NYS DPP. I also give the organization providing the NYS DPP permission to contact me. This authorization is valid for one year from date of signature.

Patient Signature_____ Date _____

To Be Completed by the Health Care Provider

NYS DPP Participant Eligibility:

- Must be at least 18 years old
- Must have a BMI ≥ 24 kg/m^2 or BMI ≥ 22 kg/m^2 if Asian
- Must have a prediabetes diagnosis or history of gestational diabetes (GDM)
- Not previously diagnosed with type 1 or type 2 diabetes
- Not pregnant

NOTE: Individuals may also be eligible to participate in the NYS DPP without a blood-based test if they score a nine or higher on the Centers for Disease Control and Prevention Prediabetes Risk Test. The test is available at http://www.cdc.gov/diabetes/prevention/

Patient Name _____ has been diagnosed with prediabetes or has a history of GDM. This patient has NOT been diagnosed with diabetes. I recommend that this patient participate in the NYS DPP.

Prediabetes Test Results (Check one and/or enter value):

☐ History of gestational diabetes

☐ 2-hour plasma glucose (OGTT) = _____ mg/dL (Must be 140-199 mg/dL)

☐ Hemoglobin A1C = _____ % (Must be 5.7%–6.4%)

☐ Fasting plasma glucose (FPG) = _____ mg/dL (Must be 100-125 mg/dL)

Patient's Height _____ (inches) Weight _____ (pounds) BMI _____ (kg/m^2)

Provider Name (Print)_____ Contact Phone Number_____

Practice Name _____

Provider Signature _____ Date _____

FOR NYS DPP ADMINISTRATIVE USE ONLY

Date Received _____ First Session Scheduled For _____

Location_____ Initials _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have received a copy of the NYS DPP brochure, and/or my provider explained to me about the program for which I am eligible. I agree and request that the health information on the front of this form be released to the community-based diabetes prevention program for the purpose of providing a referral. I have the right to revoke this authorization at any time by writing to the health care provider named on the front page, except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

Promotional support for the NYS DPP is provided by the New York State Department of Health Diabetes Prevention and Control Program.
The NYS DPP is part of the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention.