Health care practitioner referral form to a diabetes prevention program

PATIENT INFORMATION First name Address Last name City Gender IMale Birth date (mm/dd/yy) ZIP code Email Phone By providing your information above, you authorize your health care practitioner to provide this information to a diabetes prevention program provide, who may in turn use this information to communicate with you regarding its diabetes prevention program. PRACTITIONER INFORMATION (COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Eligible range Body Mass Index (BMI) Eligible range ** Hemoglobin A1C 5.7–6.4% ** Testing Plasma Glucose 100–125 mg/dL ** 2-hour plasma glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): For Medicare requirements, I will maintain this signed original document in the patient's medical record. <th>Send to: Fax:</th> <th></th> <th>Email:</th> <th></th> <th></th>	Send to: Fax:		Email:									
Last name City Health insurance City Gender □Male □Female State Birth date (mm/dd/yy) ZIP code Email Phone Phone By providing your information above, you authorize your health care practitioner 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 (COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Eligible range Sody Mass Index (BMI) Eligible range *** Fasting Plasma Glucose 100–125 mg/dL *** Fasting Plasma Glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): 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 (insert program/organization name here) for the purpose of determing my eligibility for the diabetes prevention program and conducting other activities as permitted by law.	PATIENT INFORMA	TION										
Health insurance City Gender Male Female State Birth date (mm/dd/yy) ZIP code Email Phone By providing your information above, you authorize your health care practitioner 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 (COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Address Practice contact City Phone State Fax ZIP code Eligibility = >24* (>22 if Asian) Blood test (check one) Eligibility = >24* (>22 if Asian) Blood test (check one) Eligibility = >24* (>22 if Asian) Eligibility = >24* (>22 if Asian) Blood test (check one) Eligibility = >24* (>22 if Asian) Eligibility = >24* (>22 if Asian) Blood test (check one) Eligibility = >100-125 mg/dL	First name			Address								
Gender Male Female State Birth date (mm/dd/yy) ZIP code Email Phone By providing your information above, you authorize your health care practitioner 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 (COMPLETED BY HEALTH CARE PRACTITIONER) Phone State Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Complete State Fax ZIP code SCREENING INFORMATION Eligible range Cele (check one) Eligible range ** Hemoglobin A1C 5.7–6.4% ** Trasting Plasma Glucose 100–125 mg/dL *** Throu plasma glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): For Medicare requirements, I will maintain this signed original document in the patient's medical record. Date Practitioner signature Program/organization name here) 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 p	Last name											
Birth date (mm/dd/yy) ZIP code Email Phone By providing your information above, you authorize your health care practitioner 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 (COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Body Mass Index (BMI) Blood test (check one) Eligibile range ** Fasting Plasma Glucose 100–125 mg/dL ** Fasting Plasma Glucose 100–125 mg/dL ** 2-hour plasma glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): 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 (insert program/organization name here) 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 may and that this authorization is voluntary. I understand that I may revoke	Health insurance	2		City								
Email Phone By providing your information above, you authorize your health care practitioner 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 (COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Eligibility = >24* (>22 if Asian) Blood test (check one) Eligibility = >24* (>22 if Asian) Blood test (check one) Eligible range ** Fasting Plasma Glucose 100-125 mg/dL ** Fasting Plasma Glucose 100-125 mg/dL ** 2-hour plasma glucose (75 gm OGTT) 140-199 mg/dL Date of blood test (mm/dd/yy): 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 (insert program/organization name here) 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.	Gender 🗆	Male □Female		State								
By providing your information above, you authorize your health care practitioner 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 (COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Eligibility = >24* (>22 if Asian) Blood test (check one) Eligible range Test result (one only)	Birth date (mm/o	dd/yy)		ZIP code								
prevention program provider, who may in turn use this information to communicate with you regarding its diabetes prevention program. PRACTITIONER INFORMATION (COMPLETED BY HEALTH CARE PRACTITIONER) Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Eligibility = ≥24* (≥22 if Asian) Body Mass Index (BMI) Eligibile range Test result (one only) ** ** Hemoglobin A1C 5.7–6.4% ** Fasting Plasma Glucose 100–125 mg/dL ** 2-hour plasma glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): 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 (insert program/organization name here) 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 receive	Email			Phone								
Physician/NP/PA Address Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Body Mass Index (BMI) Eligibility = ≥24* (≥22 if Asian) Blood test (check one) Eligible range	prevention prog	ram provider, who may in	-									
Practice contact City Phone State Fax ZIP code SCREENING INFORMATION Body Mass Index (BMI) Eligibility = ≥24* (≥22 if Asian) Blood test (check one) Eligible range *** Hemoglobin A1C 5.7–6.4% *** Fasting Plasma Glucose 100–125 mg/dL *** 2-hour plasma glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): For Medicare requirements, I will maintain this signed original document in the patient's medical record. Date Pattioner signature By signing this form, I authorize my physician to disclose my diabetes screening results to the (insert program/organization name here) 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.	PRACTITIONER INF	ORMATION (COMPLETED BY H	HEALTH CARE PRACTITION									
Phone State Fax ZIP code SCREENING INFORMATION Body Mass Index (BMI) Eligibility = ≥24* (≥22 if Asian) Blood test (check one) Eligible range Test result (one only)	-			Address								
Fax ZIP code SCREENING INFORMATION Body Mass Index (BMI) Eligibility = ≥24* (≥22 if Asian) Blood test (check one) Eligible range Test result (one only)	Practice contact			City								
SCREENING INFORMATION Body Mass Index (BMI) Eligibility = ≥24* (≥22 if Asian) Blood test (check one) Eligible range Test result (one only)	Phone											
Body Mass Index (BMI) Eligibility = ≥24* (≥22 if Asian) Blood test (check one) Eligible range Test result (one only) ** Hemoglobin A1C 5.7–6.4%	Fax			ZIP code								
Blood test (check one) Eligible range Test result (one only)												
 Hemoglobin A1C 5.7–6.4% Fasting Plasma Glucose 100–125 mg/dL 2-hour plasma glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): 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 (insert program/organization name here) 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. 	-			<u>></u> 24* (<u>></u> 22 if Asian)								
 Fasting Plasma Glucose 100–125 mg/dL					Test result (one only)							
 2-hour plasma glucose (75 gm OGTT) 140–199 mg/dL Date of blood test (mm/dd/yy): 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 (insert program/organization name here) 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. 	5											
Date of blood test (mm/dd/yy): 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 (insert program/organization name here) 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.	Fasting Plasm	a Glucose	100–125 mg/dL									
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 (insert program/organization name here) 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. I understand that I may revoke this authorization at any time by notifying my physician in writing.	2-hour plasm	a glucose (75 gm OGTT)	140–199 mg/dL									
Date Practitioner signature By signing this form, I authorize my physician to disclose my diabetes screening results to the (insert program/organization name here) 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 of blood te	st (mm/dd/yy):										
By signing this form, I authorize my physician to disclose my diabetes screening results to the (insert program/organization name here) 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.	For Medicare rec	quirements, I will maintai	n this signed original c	locument in the patient's	medical record.							
 program/organization name here) 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		Practitioner signat	ure								
	NAL	program/organization name here) for the purpose of determining my eligibility for the diabetes										
Date Patient signature	OP ⁻			, , , ,								
		Date P	atient 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. 05/30/14

*These BMI levels reflect eligibility for the National DPP as noted in the <u>CDC Diabetes Prevention Recognition Program Standards and Operating Procedures</u>. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of \geq 23 for Asian Americans and \geq 25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

BMI calculation chart

WEIGHT	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390	400
HEIGHT																															
5'0"	19	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57	59	61	63	65	67	69	71	72	74	76	78
5'1"	18	20	22	24	26	28	30	32	34	36	37	39	42	44	45	47	49	51	53	55	57	59	61	63	64	66	68	70	72	74	76
5'2"	18	20	22	23	25	27	29	31	33	34	36	38	40	42	44	46	48	50	51	53	55	57	59	61	62	64	66	68	70	72	73
5'3"	17	19	21	23	24	26	28	30	32	33	35	37	39	41	43	44	46	48	50	52	53	53	57	59	60	62	64	66	67	69	71
5'4"	17	18	20	22	24	25	27	29	31	32	34	36	38	40	41	43	45	46	48	50	52	53	55	57	59	60	62	64	65	67	69
5'5"	16	18	20	21	23	25	26	28	30	31	33	35	37	38	40	42	43	45	47	48	50	52	53	55	57	58	60	62	63	65	67
5'6"	16	17	19	21	22	24	25	27	29	30	32	34	36	37	39	40	42	44	45	47	49	50	52	53	55	57	58	60	62	63	65
5'7"	15	17	18	20	22	23	25	26	28	29	31	33	35	36	38	39	41	42	44	46	47	49	50	52	53	55	57	58	60	61	63
5'8"	15	16	18	19	21	22	24	25	27	28	30	32	34	35	37	38	40	41	43	44	46	47	49	50	52	53	55	56	58	59	61
5'9"	14	16	17	19	20	22	23	25	26	28	29	31	33	34	36	37	39	40	41	43	44	46	47	49	50	52	53	55	56	58	59
5'10"	14	15	17	18	20	21	23	24	25	27	28	30	32	33	35	36	37	39	40	42	43	45	46	47	49	50	52	53	55	56	58
5'11"	14	15	16	18	19	21	22	23	25	26	28	29	31	32	34	35	36	38	39	41	42	43	45	46	48	49	50	52	53	55	56
6'0"	13	14	16	17	19	20	21	23	24	25	27	28	30	31	33	34	35	37	38	39	41	42	44	45	46	48	49	50	52	53	54
6'1"	13	14	15	17	18	19	21	22	23	25	26	27	29	30	32	33	34	36	37	38	39	41	42	44	45	46	48	49	50	52	53
6'2"	12	14	15	16	18	19	20	21	23	24	25	27	28	30	31	32	33	35	36	37	39	40	41	42	44	45	46	48	49	50	51
6'3"	12	13	14	16	17	18	19	21	22	23	24	26	28	29	30	31	33	34	35	36	38	39	40	41	43	44	45	46	48	49	50
6'4"	12	13	14	15	17	18	19	20	21	23	24	26	27	28	29	31	32	33	34	35	37	38	39	40	41	43	44	45	46	48	49
6'5"	11	13	14	15	16	17	19	20	21	22	24	25	26	27	29	30	31	32	33	34	36	37	38	39	40	42	43	44	45	46	48
Blue Underweight: Less than 18.5					Gree	Green Healthy Weight: 18.5 - 24.9						Yello	w Ove	rweight:	25 - 29.	9		Orange Obese: 30 - 39.9							Red	Extreme	Obesity	r: 40 or g	greater		

BMI stands for "BODY MASS INDEX" which is an estimate of total body fat based on height and weight. It is used to screen for weight categories that may lead to health problems. THE GOAL for most people is to have a BMI in the green area. It is usually best for your BMI to stay the same over time or to gradually move toward the green area.