Be Your Best – Medical Clearance Form

Be Your Best Diabetes Prevention Program is a 10 month lifestyle intervention program shown to reduce individual risk of type 2 diabetes and cardiovascular disease through modest weight loss, diet changes, and physical activity. This program is offered through the Missoula City-County Health Department and is led by a registered dietitian and group exercise specialist.
Please complete this form in its entirety and fax to 258- 4906, Attn: Heather Sauro, MS, RD.

Patient Name: ____ **Date of Birth:** ___________ ❑ **Female** ❑ **Male**

Medical eligibility
(All of the following must be checked in order to be medically eligible)

- ❑ BMI >25 Ht: ____________ Wt:____________ BMI:___________
- ❑ 18 years or older
- ❑ No diagnosis of type 2 diabetes or unstable cardiac disease
- ❑ Able to participate in moderate physical activity, ≥ 150 mins/week
- ❑ Able to understand and participate in lifestyle intervention including detailed food journaling
- ❑ Expresses readiness to consider changing diet and physical activity
- ❑ No severe mental health diagnosis or alcohol/substance abuse that would affect successful participation (by provider judgment)
- ❑ For women: more than 6 months post-partum, not pregnant, or planning pregnancy in the next year

Patient has following risk factors
(Please check all that apply. Patients need AT LEAST ONE other risk factor for eligibility)

- ❑ History of Gestational Diabetes
- ❑ Baby > 9 pounds birth weight
- ❑ Current Pre-Diabetes (impaired Fasting Blood Glucose = 100-125)
  - ❑ Metformin prescribed
- ❑ Hypertension ***(BP > 130/85)***
  - ❑ HTN medication prescribed
- ❑ Dyslipidemia (***TG > 150mg/dl; LDL > 130mg/dl; HDL < 50 (women), HDL < 40 (men))***
  - ❑ Lipid lowering medication prescribed

Patient Contact Information:

____
Name

____
Phone

____
Street Address

____
City /State/ Zip

Patient Labs
(Blood pressure, fasting glucose and fasting lipid panel within the past 6 months ARE REQUIRED. HbA1C is recommended, but optional. The results can be attached or entered below. Please include both normal and abnormal results.)

- ❑ Blood Pressure: ______________________________ Date:_________________________
- ❑ Fasting Blood Glucose: ______________________________ Date:_________________________
- ❑ HgbA1C *(optional)*: ______________________________ Date:_________________________
- ❑ Total Cholesterol: ______________________________ Date:_________________________
- ❑ Triglycerides: ______________________________ Date:_________________________
- ❑ HDL Cholesterol: ______________________________ Date:_________________________
- ❑ LDL Cholesterol: ______________________________ Date:_________________________

I am referring this patient to the Be Your Best Diabetes Prevention Program for medical condition(s) identified above.

____ ______________________________
Physician /Provider name Affiliation

____ ______________________________
Physician /Provider Signature Date