MEDICAL CLEARANCE AND REFERRAL FORM

Montana Diabetes Prevention Program

Today's Date (MM/DD/YY)**:** _____/_____/_____

Patient Information

Last Name: _____ **First Name:** _____ **MI:** ____

Distance traveled to program site: _____miles (one way)

Demographics

Date of Birth (MM/DD/YY)**:** ____/____/_____ **Gender:** Male Female

Race:
American Indian or Alaska Native
Asian
Black or African American
Hawaiian Native or Pacific Islander
White
Multiple Races
Declined
Unknown

Education:
< High school
High school
Some college or vocational school
College degree
Declined
Unknown

Ethnicity:
Hispanic or Latino
Not Hispanic or Latino
Unknown

Household Income:
< $15,000
$15,000 - $24,999
$25,000 - $49,999
$50,000 - $74,999
$75,000+
Declined
Unknown

Employment Status:
Full Time
Part Time
Unemployed
Retired
Declined
Unknown

Contact

Email: _____ **Mobile Phone:** _____-_____-_____

Home Phone: _____-_____-_____ **Work Phone:** _____-_____-_____

Notification Preference (circle one): Texts Emails Texts & Emails None

Leave call back information ONLY at the following numbers (circle): Mobile Home Work

Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

How did you hear about DPP? (Circle all that apply)

Billboard	Brochure/Post Card	Coworker	Carehere
Flyer	Former DPP Participant	Friend/Family	Mailing
Medicaid	Medicaid Expansion (HELP)	Newspaper	Newsletter
Physician Radio	Television	Website	WIC
Other Provider	Other: _____		

Insurance

Current State of Montana Employee (circle): Yes No

Primary Insurance: _____ **Secondary Insurance:** _____

If Medicaid, 9-digit Client ID (Medicaid ID/Recipient Original ID): _____

Medical/Disability

Yes	No	Declined	Unknown	**Diagnosed with arthritis**
Yes	No	Declined	Unknown	**Deaf or has serious difficulty hearing**
Yes	No	Declined	Unknown	**Blind or has serious difficulty seeing, even when wearing glasses**
Yes	No	Declined	Unknown	**Because of a physical, mental, or emotional condition, has a serious difficulty concentrating, remembering, or making decisions**
Yes	No	Declined	Unknown	**Has serious difficulty walking or climbing stairs**
Yes	No	N/A		**Pregnant**

Medical Eligibility Criteria

Patient must be
1. Age 18 years or over AND
2. Overweight/obese BMI (BMI ≥ 24 kg/m^2 or if Asian, BMI ≥ 22 kg/m^2) AND
3. Have one or more of the risk factors listed:
   - (a) Diagnosed with certain conditions
   - (b) History of certain risk factors
   - (c) High risk score
   - (d) Elevated blood pressure level of ≥130/85 mmHg
   - (e) Abnormal lipid levels of HDL <50 mg/dL for women or <40 mg/dL for men, LDL ≥130 mg/dL, or triglycerides ≥200 mg/dL
   - (f) Elevated blood glucose level of 75-gram oral glucose tolerance test (OGTT) with 2-hour plasma glucose is 140-199 mg/dL, fasting plasma glucose (FPG) is 100-125 mg/dL, or A1C 5.7-6.4%
   - (g) Taking medication for certain conditions

1. **Age 18 years or over** Yes No
2. **Overweight or Obese** Weight: _____ lbs Height: _____ in BMI: _____ kg/m^2

3. At least one of the following risk factors.

a. Diagnosis of

Yes No Declined Unknown **Hypertension**
Yes No Declined Unknown **Dyslipidemia**
Yes No Declined Unknown **Pre-Diabetes, Impaired Fasting Glucose (IFG), or Impaired Glucose Tolerance (IGT)**

b. History of

Yes No Declined Unknown N/A **Gestational Diabetes Mellitus (GDM)**
Yes No Declined Unknown N/A **Gave Birth to a Baby > 9 lbs**

c. Result from the CDC Pre-Diabetes Screening Test

Prediabetes Risk Score: _____

d. High Blood Pressure

Date measured: ____/____/_____
Systolic: _____ mmHg Diastolic: _____ mmHg

e. Dyslipidemia

Date measured: ____/____/_____
HDL: _____ mg/dL LDL: _____ mg/dL Triglycerides: _____ mg/dL

f. Abnormal Glucose

Date measured: ____/____/_____
2-hour OGTT: _____ mg/dL or Fasting plasma glucose: _____ mg/dL
A1C: _____ %

g. Medications

Yes No Declined Unknown **Hypertension**
Yes No Declined Unknown **Lipid**
Yes No Declined Unknown **Metformin**

Clinical Indicators

a. Medications

Yes No Declined Unknown **PTSD, pain, anxiety, mental illness, sleeplessness or depression**

b. Tobacco Use

Current User Former User Never Used Declined Unknown

c. Physical Activity

Self-reported physical activity minutes per week: _____

d. Diagnosis of

Yes No Declined Unknown **Sleep apnea**

I have reviewed the medical eligibility information above, and wish to refer this patient to the Montana Diabetes Prevention Program on that basis.

Referring Provider Signature *(required)*:_____ **Date:** _____

Primary Provider

Last Name: _____ **First Name:** _____

Practice Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

► **TO MAKE A REFERRAL TO THE PROGRAM:**

- Include "**Patient Information**"
- Indicate "**Medical Eligibility Criteria**"
- **Signature** of Referring Provider
- **Send** referral form to the contact for the organization delivering the Diabetes Prevention Program

  Find a DPP

  Program Name:

  Phone:

  Fax:

  Email:

  Mailing address: