



Diabetes Prevention Program REFERRAL FORM

Patient Name: _____

Date of Birth: _____ Phone: _____ Email: _____

To qualify, participants must:

1. Be at least 18 years of age; and
2. Be overweight or obese (Body Mass Index ≥ 25 , ≥ 22 if Asian); and
3. Have prediabetes, as verified by a blood test

****To be completed by health care provider****

BODY MASS INDEX

Height: _____ inches Weight: _____ pounds BMI: _____ kg/m² (Must be ≥ 25 , ≥ 22 if Asian)

PREDIABETES INFORMATION (check all that apply **AND** enter value):

_____ Fasting plasma glucose (FPG) _____ mg/dL (100-125 mg/dL) or

_____ 2-hour plasma glucose (OGTT) _____ mg/dL (140-199 mg/dL) or

_____ Hemoglobin A1C _____ % (5.7%-6.4%)

_____ Previous GDM (may be self-reported)

I recommend that this patient participate in a National Diabetes Prevention Program recognized or pending recognition from CDC, where he/she will set goals to achieve a 7% weight reduction through changes in nutrition and physical activity (up to 150 minutes per week - equivalent to brisk walking).

Provider Name: _____

Provider Signature: _____ Date: _____

Practice Contact: _____ Phone: _____

Practice Name: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Thank you for your referral!

Make a copy and provide the completed form to the patient, who may contact a local program for more information and to enroll:

Find out more about
Diabetes Prevention Programs
Call: **211 Idaho CareLine**
Visit: **preventdiabetes.dhw.idaho.gov**

Contact Panhandle Health District to Enroll:
Natalie Colla, RDN, LDN, Lifestyle Coach
8500 N Atlas Rd
Hayden, ID 83835
208-415-5293 (Phone)
208-415-5101 (Fax)
ncolla@phd1.idaho.gov



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