UPMC Western MD Diabetes Prevention Program Referral Form

****Should be completed by health care provider (Provider referral not required) ****

Patient Name:	**Patient Date of Birth:**
Patient Address: **City:** **State:** **Zip:**	**Patient Phone:** **Cell:** **Patient Email:**

To qualify, participants must:

- ❑ Be at least 18 years of age; **and**
- ❑ Be overweight or obese (Body Mass Index ≥25, ≥23 if Asian); **and**
- ❑ Have no previous diagnosis of Type 1 or Type 2 diabetes: **and**
- ❑ Have prediabetes, as verified by a blood test **or** history of gestational diabetes.

Body Mass Index:
Height: _____ inches **Weight**: _____ pounds **BMI**: _____ kg/m2 (Must be ≥25, ≥ 23 if Asian)

Pre-Diabetes 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%)
- ❑ History of Gestational Diabetes
- ❑ Have a positive screening for prediabetes based on the Prediabetes Risk Test https://www.cdc.gov/prediabetes/takethetest/

Provider Information:

Provider Name: **Practice Name:**	**Practice Address:** **City:** **State:** **Zip:**
Practice Phone: **Practice Fax:**	

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I agree and request that the health information on this form be released to UPMC for the purpose of referring me to the Diabetes Prevention Program. I have the right to revoke this authorization at any time by contacting UPMC Wellness Department. I understand that signing this authorization is voluntary. I understand this information is collected solely for data tracking purposes and that my personally identifiable information will be kept secure according to the Health Information Portability and Accountability Act (HIPAA).

Patient name (print): _____

Patient Signature: _____ Date: _____

FAX COMPLETED FORM TO: Community Health, UPMC Western Maryland
Fax: 240-964-8415