MEDICAL CLEARANCE AND REFERRAL FORM
Montana Diabetes Prevention Program

Patient Information **Today's Date:** ____/____/_____

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

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

Primary Phone: _____-_____-_____

Email: _____

Address: _____

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

Primary Provider Name: _____

Address: _____

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

Medical Eligibility Criteria

1. **Age 18 years or over**
2. **Overweight or Obese**
   (Eligible if body mass index (BMI) ≥ 25 kg/m^2; ≥ 23 if Asian)
   Weight: _____ lbs (up to one decimal place)
   Height: _____ in
   BMI: _____ kg/m^2 (up to one decimal place)
3. **At least one of the following criteria. Please provide all available data.**
   a. **High Blood Pressure**
   (Eligible if ≥ 130/80 mmHg or taking blood pressure control medication)
   Date measured: ____/____/_____
   Systolic: _____ **Diastolic:** _____
   Taking blood pressure control/hypertension medication (circle)**:** Yes No
   b. **Dyslipidemia**
   (Eligible if HDL <50 mg/dL for women or <40 mg/dL for men, LDL ≥ 130 mg/dL, Triglycerides ≥ 150 mg/dL, or taking lipid control medication)
   Date measured: ____/____/_____
   HDL cholesterol: _____ mg/dL
   LDL cholesterol: _____ mg/dL
   Triglycerides: _____ mg/dL
   Taking lipid medication (circle)**:** Yes No

c. **Diagnosis of Pre-Diabetes, Impaired Fasting Glucose (IFG), or Impaired Glucose Tolerance (IGT)**
(Eligible if diagnosed)
Diagnosed with pre-diabetes, IFG, or IGT (circle)**:** Yes No

d. **CDC Pre-Diabetes Screening Test**
(Eligible if risk score ≥ 5)
Risk Score: _____

e. **Abnormal Glucose**
(Eligible if 75-gram oral glucose tolerance test (OGTT) with 2-hour plasma glucose is 140-199 mg/dL (IGT), fasting plasma glucose is 100-125 mg/dL (IFG), or A1C 5.7-6.4%)
Date measured: ____/____/_____
2-hour OGTT plasma glucose: _____ mg/dL
Fasting plasma glucose: _____ mg/dL
A1C: _____ %
Taking metformin (circle)**:** Yes No

f. **History of Gestational Diabetes Mellitus (GDM)**
(Eligible if "Yes" to either)
History of GDM (circle)**:** Yes No

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:**_____

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

- Include "**Patient Information**"
- Indicate "**Medical Eligibility Criteria**"
- **Signature** of Referring Provider
- **Send** referral form to:
  Program Name:

  Phone:

  Fax:

  Email:

  Mailing address: