PREVENT T2
A PROVEN PROGRAM TO PREVENT OR DELAY TYPE 2 DIABETES

MEDICAL CLEARANCE AND REFERRAL FORM
Montana Diabetes Prevention Program

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

Name: _____ ------ Date of Birth:_____
Primary Phone ----------_____
Primary Insurance: _____ Physician Name: _____
If Medicaid, 9-digit Client ID (Medicaid ID/Recipient Original ID): _____
Please complete all criteria that pertain to the patient

Medical Eligibility Criteria

1. **Age 18 years or over**
2. **Overweight or Obese** (BMI ≥ 25)
3. **Additional qualifying criteria** (at least one)
   a. **High Blood Pressure**
   (Eligible if ≥ 130/80 mmHg or taking blood pressure control medication)
   b. **Dyslipidemia**
   (Eligible if HDL <50 mg/dL for women or <40 mg/dL for men, LDL ≥ 130 mg/dL, Triglycerides ≥ 200 mg/dL, or taking lipid control medication)
   c. **Diagnosis of Pre-Diabetes**
   d. **Abnormal Glucose**
   (Eligible if fasting plasma glucose is 100-125 mg/dL (IFG), or A1C 5.7-6.4%
   e. **History of Gestational Diabetes**

Medical History

1. **Does patient take medication for these conditions:**
   a. **High cholesterol/triglycerides** yes/no
   b. **Abnormal glucose** yes/no
   c. **Hypertension** yes/no
2. **Lab results within the past 12 months**
   a. **HDL Cholesterol_____ date_____**
   b. **LDL Cholesterol_____ date_____**
   c. **Triglycerides_____ date_____**
   d. **Fasting Blood Glucose_____ date_____ or A1C_____ date_____**
   e. **Blood Pressure _____ date_____**
3. **Height _____ Weight _____ BMI _____date_____**
4. **Diagnosed with arthritis** yes/no (please circle one)
5. **Diagnosed with diabetes** yes/no (please circle one)

I have reviewed the medical eligibility information above and wish to refer this patient to the Diabetes Prevention Program on that basis.
Please email or fax to Courtney Antonich catonich@missoulacounty.us

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

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