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 Nancy Liner, RD nliner@missoulacounty.us

Referring Provider Signature *(required)*:**___________________________________** **Date:_________**

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