

MEDICAL CLEARANCE
FORM
Montana Diabetes



AND REFERRAL
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 \geq 25)
3. Additional qualifying criteria (at least one)
 - a. High Blood Pressure
(Eligible if \geq 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 \geq 130 mg/dL, Triglycerides \geq 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 Chase cchase@missoulacounty.us

Referring Provider Signature (required): _____ Date: _____

Fax: 406-258-4906 Phone: 406-258-4935 301 West Alder Street Missoula, Mt 59802

