DIABETES PREVENTION REFERRAL FORM

Please fill out the patient's information and return to the following contact:

Eastern Shore Area Health Education Center
Attn: Shakira Abdulai
Email: sabdulai@esahec.org Fax: 410-221-2605

Patient Information

NAME		ADDRESS: (STREET ADDRESS)	
Telephone NO.		CITY	
BIRTHDATE (MM/DD/YY)		STATE	
EMAIL ADDRESS		HEALTH INSURANCE	
EMPLOYER		PREFERRED TIME OF CONTACT	

REFERRAL ELIGIBILITY

To be eligible, your patient MUST:

- ☐ Be 18 years of age or older
- ☐ Have a Body Mass Index (BMI) of ≥25 (23 or higher if Asian American). **Record BMI: _____**
- ☐ Not be previously diagnosed with Type 1 or Type 2 diabetes.
- ☐ Not be pregnant.

AND

One of the following must be true:

Received a blood test in the prediabetes range within the past year	**-OR-**	**Meet one of these Medicare Diabetes Prevention Program criteria**
Hemoglobin A1C 5.7-6.4%	Result:	Previously diagnosed with gestational diabetes (diabetes during pregnancy)
Fasting plasma glucose: 100-125 mg/dL	Result:	High-risk result (5 or higher) on Prediabetes Risk Test
Two-hour plasma glucose (after 75g glucose load): 140-199mg/dL	Result:	
Other:	Result:	

PROVIDER INFORMATION

Provider Name		Name of Practice (print)	
Phone Number		Email/Fax	

Provider Signature _____ **Date of Signature** ____ / ____ / ____

I authorize my healthcare provider to send this referral to the Eastern Shore Area Health Education Center who will contact me with more information about the Diabetes Prevention Program.

Patient Signature_____**Date**_____