

# National Diabetes Prevention Program (National DPP) lifestyle change program referral template

This resource can be used as a guide for creating a form to refer patients from clinical settings to a National DPP lifestyle change program provider. The elements noted comprise potential key information to include in a referral and a sample template is also displayed below.

- Patient information: Name, contact information (address, phone, email), birth date/age, gender, health insurance, employer, preferred method of contact, preferred time to contact.
- Health care provider information: Physician/provider name, practice name, practice contact name, practice information (address, phone, fax, etc.)
- Other information: Date of referral, authorization information (language that meets your organization's specific legal requirements for privacy and security, etc.), eligibility for program information (patient body mass index, medical history and blood test results), signatures of physician/ordering provider and patient OR patient representative.

This resource is provided for informational purposes only and does not constitute legal advice. Please consult with a qualified legal advisor to create a resource for use within your organization.

**Send to (program name):**

**Fax/Email:**

Patient information		
Name	Address	
Gender	City	
Birth date (mm/dd/yy)	State	
Employer	ZIP code	
Preferred method of contact	Phone	
Preferred time to contact	Health Insurance	
Health care provider information		
Physician/NP/PA name	Address	
Practice name	City	
Phone	State	
Fax	ZIP code	
Date: _____ Health care provider signature: _____		
Authorization for release of health information [Insert your organization's specific legal language here.]		
Referral eligibility information:		
Criteria	Reference range	Result
<input type="checkbox"/> Body Mass Index (BMI)	Eligibility = $\geq 25$ ( $\geq 23$ if Asian)	_____
<input type="checkbox"/> Blood test		
• Hemoglobin A1C	5.7-6.4%	_____
• Fasting plasma glucose	100-125 mg/dL	_____
• 2-hour oral glucose tolerance test	140-199 mg/dL	_____
Date of blood test (mm/dd/yy): _____		
<input type="checkbox"/> History of Gestational Diabetes		
Date: _____ Patient or representative signature: _____		
(Basis of representative's authority to sign on behalf of patient: _____)		