St. Vincent Diabetes Center Diabetes and Heart Disease Prevention Program (DPP)

Patient's Name: _____ **Date of Birth**: _____

Home Phone: _____ **Work Phone:** _____

A. Medical Suitability Criteria:

- ❑ Age >18 yrs
- ❑ Able to participate in moderate physical activity for at least 150 minutes per week
- ❑ **Not already diagnosed with diabetes**, cancer (in treatment), unstable cardiac disease, &/or ESRD
- ❑ Not pregnant or planning pregnancy within 6 months
- ❑ No alcohol or substance abuse that may affect ability to participate fully

B. Please ask your patient this question to evaluate his or her readiness for behavior change:

How ready are you to make improvements to your eating and or physical activity habits?

If all the suitability criteria are met and patient shows readiness to change behavior, complete the rest of this form and mail to:
Billings YMCA, Attn: Diabetes and Heart Disease Prevention Program, 402 North 32nd, Billings, Montana 59101.
The patient will be contacted for individual initial assessment and classes. The DPP phone number is **(406) 237-8599**.

C. Medical Eligibility:

Patient must be overweight/obese to be eligible, **AND** meet at least one additional criteria to qualify.
Please check all that apply and **include results from within last 6 months, even if the results are within normal limits.**

❑ **Overweight/Obese =** BMI 25 or greater (we will calculate): Weight: _____ lbs Ht: _____ in

Pre-Diabetes

- ❑ Impaired fasting glucose (100-125 mg/dl) Fasting glucose_____ Date:_____
- ❑ Impaired glucose tolerance (140-199 mg/dl) Non-fasting glucose_____ Date: _____
- ❑ HgbA1c (5.7-6.4%) HgbA1c _____ Date:

History of Gestational Diabetes

- ❑ Previously diagnosed with GDM
- ❑ Gave birth to a baby weighing 9 lbs or more

Lipid Disorder: (check all that apply):

- ❑ Low HDL (for women: < 50 mg/dl, for men < 40 mg/dl) HDL: _____ Date: _____
- ❑ Elevated LDL (>130 mg/dl) LDL: _____ Date: _____
- ❑ Elevated triglycerides (>150 mg/dl) TG: _____ Date: _____
- ❑ Total Cholesterol: _____ Date: _____
- ❑ On prescribed medication for lipid disorder Medication: _____

Hypertension:

- ❑ BP 130/85 or higher BP: _____ Date: _____
- ❑ On prescribed medication for hypertension Medication: _____

D. Provider Approval : I have reviewed the medical eligibility and suitability information above. This patient meets criteria and has been medically cleared to participate in the DPP to treat the medical conditions checked above.

Provider Signature: _____ Date: _____

Print Provider Name: _____