MOLINA HEALTHCARE

Your Extended Family.

# National Diabetes Prevention Program

## Provider Fax Referral Form

### I AM RECOMMENDING:

_____

(First Name) (MI) (Last Name)

_____

(Patient Phone Number) (Patient Email)

Enroll in the National Diabetes Prevention Program lifestyle change program based on the following eligibility criteria *(all three boxes required):*

- ☐ 18 years or older
- ☐ BMI ≥ 24 kg/m$^2$ (≥22 if Asian)
- ☐ Diagnosis of prediabetes or GDM based on (check one or more)
  - ☐ Fasting blood glucose (range 100-125 mg/dl)
  - ☐ 2-hour glucose (range 140-199 mg/dl)
  - ☐ HbA1c (range 5.7-6.4)
  - ☐ Previous GDM (may be self-reported)

### HEALTH CARE PROVIDER INFORMATION

NAME _____

SIGNATURE _____

DATE _____

CLINIC _____

PHONE _____

FAX _____

I agree to be contacted about this program:

PATIENT SIGNATURE _____

***Please fax this completed form to (414)214-2488 or call Molina Healthcare at <(414)755-5155>***

*Make a copy for your records and return the form to the patient. Your patient will be called for class registration.*

FOR MORE INFORMATION VISIT:
**www.cdc.gov/diabetes/prevention**

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