NATIONAL DIABETES PREVENTION PROGRAM INTAKE FORM

(Please Print)

Today's date:	Primary Care Physician:

PARTICIPANT INFORMATION

Last name:	First:	Middle:

Height: (ft., in)	Weight (lbs.)	Birth date:	Age:	Gender:
		/ /		❑ F ❑ M

Race/Ethnicity:	❑ American Indian/Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ Native Hawaiian/Pacific Islander ❑ White

Occupation:		
Street address:	Cell phone no.:	Home phone no.:
	( )	( )

P.O. box:	City:	State:	ZIP Code:

Email Address:

Heard about program/referred by **(please check all that apply):**

❑ Dr./Physician_____

❑ Nurse

❑ Insurance Provider

❑ Hospital

❑Family/Friend

❑ Diabetes Educator

❑ Printed Ad/Poster (newsletter/paper)

❑ News (radio, online)

❑ Preventdiabetesnh.org

❑ Screening/Testing Event or Health Fair

❑ Dietitian/Nutritionist

❑ Worksite Wellness Coordinator/Program

❑ Employer

❑Dhhs.nh.gov/dphs/cdpc/diabetes/prediabetes.htm

❑ Facebook/Twitter

❑Other_____

PARTICIPANT ELIGIBILITY

(Please Indicate Prediabetes Status/Type 2 Diabetes at Risk Criteria.)

❑ BMI: ≥ 25 (Asian ≥ 22)

❑ Fasting glucose of 100 to 125 mg/dl

❑ Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl

❑A1c of 5.7 to 6.4

❑ Clinically diagnosed GDM during a previous pregnancy (may be self-reported)

❑ Positive for prediabetes based on the CDC Prediabetes Screening Test

PARTICIPANT PAYMENT/COVERAGE

National Diabetes Prevention Program Payment: ❑ Self-pay ❑ State Employee/CHERP ❑Other_____

Patient Signature *Date*

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*
Department of Health and Human Services

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