# Health care practitioner enrollment form to diabetes prevention program

| PATIENT INFORMATION | |
|---|---|
| First name | Address |
| Last name | City |
| Gender ☐ Male ☐ Female | State |
| Birth date (mm/dd/yy) | ZIP code |
| Email | Phone |
| By providing your information above, you authorize your health care practitioner to provide this information to a diabetes prevention program provider, who may in turn use this information to communicate with you regarding its diabetes prevention program. | |

| PRACTITIONER INFORMATION (COMPLETED BY HEALTH CARE PRACTITIONER) | |
|---|---|
| Physician/NP/PA | Address |
| Phone | City |
| Fax | State |
| | ZIP code |

| SCREENING INFORMATION | | |
|---|---|---|
| Body Mass Index (BMI) | | |
| Blood test (check one) | Eligible range | Test result (one only) |
| ☐ Hemoglobin A1C | 5.7–6.4% | _____ |
| ☐ Fasting Plasma Glucose | 100–125 mg/dL | _____ |
| Date of blood test (mm/dd/yy): | | |
| **Date** | **Practitioner signature** | |

OPTIONAL

By signing this form, I authorize my physician to disclose my diabetes screening test results to this clinic's diabetes prevention program and conducting other activities as permitted by law.

I understand that I am not obligated to participate in this diabetes screening program and that this authorization is voluntary.

I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation.

| **Date** | **Patient signature** |
|---|---|
| | |

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