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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