YMCA'S DIABETES PREVENTION PROGRAM INTAKE FORM

CONFIRM SELF-PAY OR WORKSITE WELLNESS

☐ Self-pay ☐ Worksite Wellness

STEP ONE: PARTICIPANT DETAILS

First name*

Middle name

Last name*

Gender*

Date of birth*

Race/Ethnicity:

☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Hispanic/Latino of any race
☐ White

STEP TWO: BMI & QUALIFICATION CRITERIA

Height (ft)*^ Height (in)*^ Weight (lbs)*^

^*self-reported*

For program participation, BMI ≥ 25. Asian individual(s) BMI ≥ 22

Meets Blood Value/Diagnosis Qualification:**

☐ A1c:________ (must be 5.7%-6.4%)
☐ Fasting Plasma Glucose:________ (must be 100-125 mg/dL)
☐ 2-hour (75 gm glucola) Plasma Glucose:_______ (must be 140-199 mg/dL)
☐ Prediabetes determined by clinical diagnosis of Gestational Diabetes (GDM) during previous pregnancy

Meets At-Risk Qualification:

Complete the questions below based on the candidate's responses.	*Yes - Points*	*No - Points*
Is the candidate a woman who has had a baby weighing more than 9 pounds at birth?	☐ - 1	☐ - 0
Does the candidate have a parent with diabetes?	☐ - 1	☐ - 0
Does the candidate have a brother or sister with diabetes?	☐ - 1	☐ - 0
Does the candidate weigh as much as or more than the weight listed for their height?	☐ - 5	☐ - 0
Is the candidate younger than 65 years of age and gets little or no activity in a typical day?	☐ - 5	☐ - 0
Is the candidate between 45 and 64 years of age?	☐ - 5	☐ - 0
Is the candidate 65 years of age or older?	☐ - 9	☐ - 0

Total Risk Score (score must be 9 or greater to qualify for enrollment in 'At-Risk' category):

STEP THREE: CONTACT INFORMATION & REFERRAL SOURCE

Email address

Street 1*

Street 2

City*

State*

Postal code*

Home phone

Work phone

Mobile phone

Referral method:

☐ Doctor/Physician
☐ Nurse
☐ Diabetes Educator
☐ Dietician/Nutritionist
☐ Practice Manager or Office Manager
☐ Dentist
☐ Optometrist/Ophthalmologist
☐ Pharmacist
☐ Screening/Testing Event or Health Fair
☐ Family/Friend or Word of Mouth
☐ Employer
☐ Insurance Company
☐ Media (TV, web, radio, print, etc.)
☐ Staff Member
☐ Other:

*Required information to complete enrollment

Please fax completed Referral Form to:
Andrea Weiler, Healthy Living Director
(P) 360-453-2190 (F) 1-844-860-1196 (HIPAA Secure Fax)

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