SELF PAY REFERRAL TO KRNC's
NATIONAL DIABETES PREVENTION PROGRAM

HEALTHCARE PROVIDER: PLEASE COMPLETE THE FOLLOWING INFORMATION

Contact Information

Patient name	
Patient phone number	
Patient address, *if available*	

CDC Biometric Information

Date of Birth
Age
Gender
Ethnicity
Measured height
Measured weight
Fasting plasma glucose
Plasma glucose measured 2 hours after a 75 gm glucose load
HbA1C
Clinically diagnosed gestational diabetes during previous pregnancy (circle: yes *or* no *or* not applicable)

Only 1 of these is required (Fasting plasma glucose, Plasma glucose measured 2 hours after a 75 gm glucose load, HbA1C)

Provider Name and Contact #:____

PLEASE FAX THIS FORM TO OUR CONFIDENTIAL FAX: 970-491-8867

If you do not have a glucose or HbA1c, please complete a screening tool and fax that to us instead. It is found at http://www.nutritioncenter.chhs.colostate.edu/programs-services/diabetes-prevention-program.aspx