MEDICAL CLEARANCE AND REFERRAL FORM
Gallatin City-County Health Department

_____ Group Lifestyle Balance - Diabetes Prevention Program
_____ Health Coaches for Hypertension Control
_____ Walk with Ease
_____ Montana Living Life Well

Patient Information

First Name: _______________________ MI: _____ Last Name: ________________________________
Gender (circle): Male         Female    Date of Birth (MM/DD/YY): ____/____/_____
Primary Phone: _______ - _______ - _________ Email: ___________________________
Address: _____________________________________________________________________________
City: ____________________________ State: _______ Zip: __________

Primary Provider Name: ____________________________
Address: _____________________________________________________________________________
City: ____________________________ State: _______ Zip: __________
Medical Eligibility Criteria

1. Age 18 years or over
2. Overweight or Obese
   (Eligible if body mass index (BMI) ≥ 25 kg/m²; ≥ 23 if Asian)
   Weight: ______________ lbs        (up to one decimal place)
   Height: ______________ in
   BMI: ______________ kg/m² (up to one decimal place)
3. At least one of the following criteria. Please provide all available data.
   a. High Blood Pressure
      (Eligible if ≥ 130/80 mmHg or taking blood pressure control medication)
      Date measured: _____/____/____
      Systolic: ___________ Diastolic: ___________
      Taking blood pressure control/hypertension medication (circle): Yes     No
   b. Dyslipidemia
      (Eligible if HDL <50 mg/dL for women or <40 mg/dL for men, LDL ≥ 130 mg/dL, Triglycerides ≥ 150 mg/dL, or taking lipid control medication)
      Date measured: _____/____/____
      HDL cholesterol: ___________ mg/dL
      LDL cholesterol: ___________ mg/dL
      Triglycerides: ___________ mg/dL
      Taking lipid medication (circle): Yes     No
   c. Diagnosis of Pre-Diabetes, Impaired Fasting Glucose (IFG), or Impaired Glucose Tolerance (IGT)
      (Eligible if diagnosed)
      Diagnosed with pre-diabetes, IFG, or IGT (circle): Yes     No
   d. CDC Pre-Diabetes Screening Test
      (Eligible if risk score ≥ 5)
      Risk Score: ___________
   e. Abnormal Glucose
      (Eligible if 75-gram oral glucose tolerance test (OGTT) with 2-hour plasma glucose is 140-199 mg/dL (IGT), fasting plasma glucose is 100-125 mg/dL (IFG), or A1C 5.7-6.4%)
      Date measured: _____/____/____
      2-hour OGTT plasma glucose: ___________ mg/dL
      Fasting plasma glucose: ___________ mg/dL
      A1C: ___________ %
      Taking metformin (circle): Yes     No
   f. History of Gestational Diabetes Mellitus (GDM)
      (Eligible if “Yes” to either)
      History of GDM (circle): Yes     No

I have reviewed the medical eligibility information above, and wish to refer this patient to the Montana Diabetes Prevention Program on that basis.

Referring Provider Signature (required): ____________________________ Date: ____________