ARE YOU AT RISK FOR

Type 2 DIABETES?

TAKE THE TEST AND FIND OUT.

Crawford County Health Department

	Question	Points	Write your score in the box
1	Are you a woman who has had a baby weighing more than 9 pounds at birth?	Yes (1 point) No (0 points)	
2	Do you have a sister or brother with diabetes?	Yes (1 point) No (0 points)	
3	Do you have a parent with diabetes?	Yes (1 point) No (0 points)	
4	Find your height on the chart. Do you weigh as much as or more than the weight listed for your height?	Yes (5 points) No (0 points)	
5	Are you younger than 65 years of age and get little or no exercise in a typical day?	Yes (5 points) No (0 points)	
6	Are you between 45 and 64 years of age?	Yes (5 points) No (0 points)	
7	Are you 65 years of age or older?	Yes (9 points) No (0 points)	
	Total score for all "Yes" answers		

At–Risk Weight Chart

Height	Weight (in Pounds)
4' 10"	129
4' 11"	133
5'0"	138
5'1"	143
5'2"	147
5'3"	152
5'4"	157
5'5"	162
5'6"	167
5'7"	172
5'8"	177
5'9"	182
5'10"	188
5'11"	193
6'0"	199
6'1"	204
6'2"	210
6'3"	216
6'4"	221

NATIONAL Diabetes PREVENTION PROGRAM
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Know your score

9 or more points: High risk for having type 2 diabetes now. You qualify for this program. **PLEASE SEE BACK SIDE OF THIS FORM.**

3-8 points: Probably not at high risk for having Type 2 diabetes now.

Crawford County Health Department

Phone: 620-231-3200

Fax: 620-235-7134

hharmon@crawfordcohd.org
danthony@crawfordcohd.org

Crawford County Health Department

Diabetes Prevention/Diabetes Self-Management Programs

PARTICIPANT REGISTRATION

First Name:	MI:	Last Name:	
Home Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email:	Date of Birth: _____ /_____ /_____	Age:	

Ethnicity (check one): ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race (check all that apply): ❑ American Indian or Alaska Native ❑ Asian
❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Gender: ❑ Male ❑ Female	Height (in inches):	Weight:

Do you have health insurance? ❑ Yes ❑ No If so, what kind? _____

Total Income:_____ ❑ Year ❑ Month ❑ Week ❑ Hour Number of Persons supported by this income: _____

I authorize:

1. The release of my medical information (including but not limited to: Fasting Plasma Glucose, 2-hour Plasma Glucose, A1C, Gestational Diabetes, BMI) to the Crawford County Health Department.
2. The CDC Lifestyle Coach or Group Leader to inform my provider about my participation in the National Diabetes Prevention Program and/or Diabetes Self-Management Program.

Signature:_____ Date:_____

PHYSICIAN REFERRAL

This is a recommendation for the adult patient named above to participate in the National Diabetes Prevention Program and/or the Diabetes Self-Management Program.

Please check all applicable patient eligibility criteria:

- ☐ 18 years or older
- ☐ BMI ≥ 24 kg/m^2 (≥ 22 if Asian)
- ☐ Previous Diagnosis of Gestational Diabetes (GDM) (may be self-reported)
- ☐ At Risk for Diabetes based on (check one or more below)
  - ☐ Fasting blood glucose (range 100-125 mg/dl)
  - ☐ 2 – Hour glucose (range 140-199 mg/dl)
  - ☐ HbA1c (range 5.7-6.4)

☐ **Diagnosed with Type I or Type II Diabetes**

☐ **A1c is > 6.4 _____**

☐ **Fasting blood glucose > 125 mg/dl _____**

Health Care Provider Information:

Signature: _____ Date: _____

Print Name: _____ Phone: _____

Address: _____ Fax: _____

NOTE: Please make a copy of this completed form and provide to the patient for follow up OR return (by fax) to the local program listed below most conveniently accessible to your patient.

Crawford County Health Department
410 E. Atkinson
Pittsburg, KS 66762

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Email: danthony@crawfordcohd.org
Or hharmon@crawfordcohd.org

STAFF ONLY: CLASS START DATE _____LOCATION _____ DSMP or NDPP_____