Western New York Integrated Care Collaborative

Diabetes Prevention Program and Medicare-Diabetes Prevention Program

Patient Recommendation / Referral

WNYICC DIABETES PREVENTION PROGRAM (WNYICC DPP) is an evidence-based program for adults with diagnosed prediabetes or who are at high risk for developing Type 2 Diabetes.

- The WNYICC DPP program has Full Recognition from the CDC and is led by a trained Lifestyle Coach utilizing the ***Prevent T2*** curriculum and meets one hour per week for 12 weeks, then tapers to monthly sessions, for 22 total sessions over 12 months.
- The program is delivered in community settings, in groups of 10-15 people, where personal lifestyle goals are set by each participant.
- The sessions cover healthy eating, physical activity, and lifestyle changes to help participants achieve the goals that lead to the prevention or delay of a diabetes diagnosis, including a 5-7% weight loss and maintenance, and a gradual increase in physical activity to 150 minutes per week.

PATIENT INFORMATION *complete in full

Name: Date of Birth: Gender: ☐ F ☐ M ☐ Other/declined

Street Address:

City : State : Zip:

Primary Phone Number: E-mail:

***Required Health Insurance Plan:** ☐ Original Medicare ☐ Medicaid ☐ Medicare Advantage ☐ Commercial ☐ No Insurance /Self-Pay ☐ Other: (specify):

Name of Patient's Health Plan:

Health Plan ID Number:

I (print patient name), _____, have read the AUTHORIZATION TO RELEASE HEALTH INFORMATION on the back of this form and give my health care provider permission to send my information directly to Western New York Integrated Care Collaborative (WNYICC). I also give the organization providing the WNYICC DPP permission to contact me. This authorization is valid for one year from date of signature. I have designated my preferred workshop location on the back of the form.

Patient Signature **Date**

☐ Patient provided verbal consent via telephone on date: _____ Initials: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER or PLAN:

FAX COMPLETED FORM TO WNYICC: 1-844-620-0739

WNYICC DPP Participant Eligibility: (All required)

- ☐ Must be at least 18 years old; Not pregnant
- ☐ Must have a BMI **> 24** kg/m^2 or BMI **> 22** kg/m^2 if self-identified as Asian
- ☐ Must have a prediabetes diagnosis ***or if Medicaid:*** history of gestational diabetes (GDM)
- ☐ Not previously diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease.
- ☐ ***If Medicare:*** Not previously participated in the Medicare Diabetes Prevention Program (M-DPP)

This patient has been diagnosed with prediabetes or has a history of GDM. This patient has NOT been diagnosed with diabetes or End-Stage Renal Disease. I recommend that this patient participate in the WNYICC DPP.

Patient's Height: (inches) **Weight:** (pounds) **BMI:** (kg/m2) ☐ **Asian**

Prediabetes Test Results (Check one and enter value): Date of test: _____ *(must be within last 12 months)*

- ☐ 2-hour plasma glucose (OGTT) = _____ mg/dl (Must be 140-199 mg/dl)
- ☐ Hemoglobin A1c: _____ % (Must be 5.7%-6.4%)
- ☐ Fasting plasma glucose (FPG) = _____mg/dl (***Medicare:*** Must be 110-125 mg/d; ***All others:*** 100-125 mg/dl)
- ☐ Individuals with ***Medicaid insurance only***: History of gestational diabetes
- ☐ Individuals with ***Medicaid insurance only***: _____ score (≥9) on the CDC Prediabetes Risk Test. The test is available at http://www.cdc.gov/diabetes/prevention/ (Must be score a nine or higher)

Provider Name (Print): **Provider Phone Number:**

Fax Number: **Name & Phone of person completing form:**

Provider Signature *(required for **Medicaid insurance** only):*

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PATIENT AUTHORIZATION TO RELEASE HEALTH INFORMATION:

I have received information about the WNYICC Diabetes Prevention Program, or my provider explained to me about the program for which I am eligible. I agree and request that the health information on the front of this form be released to the community-based diabetes prevention program for the purpose of providing a referral. I have the right to revoke this authorization at any time by writing to the health care provider named on the front page, except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

PATIENT'S PREFERRED WORKSHOP LOCATION:

Preferred site(s): ☐ YMCA Williams-Emslie ☐ YMCA Amherst Ind. Health ☐ YMCA Lockport ☐ YMCA Southtowns ☐ YMCA Ken-Ton or Delaware

Western New York Integrated Care Collaborative:

- WNYICC is a Network of local, trusted agencies in Western New York working together to provide community-based programs and services integrated with health care.
- For Questions or more information, please visit our website at: https://www.wnyicc.org/Services/Diabetes-Prevention-Program-DPP

A TRAINED LIFESTYLE COACH

CDC-APPROVED CURRICULUM

GROUP SUPPORT OVER THE COURSE OF A YEAR

the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY