



I CAN Prevent Diabetes Risk Questionnaire

This form will help your healthcare provider decide if you need a test for diabetes

You DO NOT need to answer these questions if:

- ✓ You already have diabetes
- ✓ You are pregnant now
- ✓ You were already tested for diabetes during the past year

Please check each of the following statements that are TRUE for you:

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> My blood pressure is <u>140/90</u> or <u>higher</u> , or I have been told that I have high blood pressure. | <input type="checkbox"/> I have had gestational diabetes, (diabetes during pregnancy), or I gave birth to a baby weighing more than 9 pounds. |
| <input type="checkbox"/> I have been told that my cholesterol levels are not normal. | <input type="checkbox"/> I have had gestational diabetes, (diabetes during pregnancy), or I gave birth to a baby weighing more than 9 pounds. |
| <input type="checkbox"/> I am fairly inactive. I do NOT exercise <u>more</u> often than <u>two</u> times a week. | <input type="checkbox"/> I have been told by a doctor that I am overweight (BMI >25) |
| <input type="checkbox"/> I have or had a parent with diabetes. | <input type="checkbox"/> I am <u>45</u> years of age or <u>older</u> . |
| <input type="checkbox"/> I have or had a brother, or sister with diabetes. | |

Did you check **2 or more** of the boxes above?

If NO: You are at LOW risk for having pre-diabetes or diabetes now.

You DO NOT need any further tests. You are done completing this form. Thank you.

If YES: You ARE at risk for pre-diabetes or diabetes. This does NOT mean that you have diabetes.

You will need a blood test to find out.

Discuss this form with your regular healthcare provider to determine if you need a test.

If they recommend a test and you complete it, then ask your doctor to fill in the information below and bring this completed form signed by your provider to the I CAN Prevent Diabetes program.

****Healthcare Provider Use Only****

Step 1: My patient, _____, has **pre-diabetes**; his/her (check one and enter value)

- A1C = _____ % (must be 5.7 – 6.4 %), **OR**
- Fasting plasma glucose = _____ mg/dL (must be 100 -125 mg/dL), **OR**
- 2-hour (75 gm glucose) plasma glucose = _____ mg/dL (must be 140 - 199 mg/dL)

Step 2: I (check one) DO / DO NOT recommend that this patient set goals for achieving 5 – 7% weight reduction through changes in diet and gradually increases in physical activity.

Step 3: _____ (Pt name) _____ (Pt Phone number)

is referred to the I CAN Prevention Diabetes Program.

Provider signature _____ **Date**
Clinic

Keep a copy for the pt chart and give a copy to the patient.