National Kidney Foundation® of Hawaii

Diabetes Prevention Program Intake Form

ID#_____

First name:_____**Last name:**_____

Gender: M or **F** **DOB:**_____ **Age:**_____ **Phone: (**_____**)**_____

Mailing Address:_____

Email:_____

Referral Source (Please check only one):

☐ PRIMARY CARE PROVIDER/OFFICE OR SPECIALIST ☐ SELF ☐ FAMILY/FRIENDS
☐ NON-PRIMARY CARE HEALTH PROFESSIONAL ☐ INSURANCE COMPANY
☐ EMPLOYER OR EMPLOYER'S WELLNESS PROGRAM ☐ OTHER
☐ COMMUNITY-BASED ORGANIZATION OR COMMUNITY HEALTH WORKER
☐ MEDIA (RADIO, NEWSPAPER AD, WEBSITE, ETC.)

Please complete the Prediabetes Risk Test

	Write your score:
1. **How old are you?** Younger than 40 years (0 points) 40-49 years (1 point) 50-59 years (2 points) 60 years or older (3 points)	
2. Are you a man or a woman? Man (1 point) Woman (0 points)	
3. If you are a woman, have you ever been diagnosed with gestational diabetes? Yes (1 point) No (0 points)	
4. Do you have a mother, father, sister, or brother with diabetes? Yes (1 point) No (0 points)	
5. Have you ever been diagnosed with high blood pressure? Yes (1 point) No (0 points)	
6. Are you physically active? Yes (0 points) No (1 point)	
7. What is your weight category? (See chart at right)	
Total Risk Score	

Height	Weight (lbs.)		
4'10"	119-142	143-190	191+
4'11	124-147	148-197	198+
5'0"	128-152	153-203	204+
5'1"	132-157	158-210	211+
5'2"	136-163	164-217	218+
5'3"	141-168	169-224	225+
5'4"	145-173	174-231	232+
5'5"	150-179	180-239	240+
5'6"	155-185	186-246	247+
5'7"	159-190	191-254	255+
5'8"	164-196	197-261	262+
5'9"	169-202	203-269	270+
5'10"	174-208	209-277	278+
5'11"	179-214	215-285	286+
6'0"	184-220	221-293	294+
6'1"	189-226	227-301	302+
6'2"	194-232	233-310	311+
6'3"	200-239	240-318	319+
6'4"	205-245	246-327	328+
	1 point	**2 pts**	**3 pts**
	You weigh less than the 1 point column (0 points)		

If you scored 5 or higher you are at increased risk for having prediabetes and are at high risk for type 2 diabetes.

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www.kidneyhi.org | info@kidneyhi.org

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AND/OR Provide one of the most recent Bloodwork/Lab Values *within the past 12 months:*

- ☐ Hemoglobin A1C 5.7- 6.4% : Date:_____ %_____
- ☐ Fasting Blood Glucose 100 – 125: Date:_____ Glucose:_____

Primary Ethnicity (Please check only one):

☐ American Indian or Alaska Native ☐ Asian or Asian American ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Secondary Ethnicity:

_____

PLEASE IDENTIFY SELF AS ONLY ONE: ☐ Hispanic/Latino ☐ Not Hispanic or Latino

Who is your Primary Care Physician:

_____

Primary Insurance: _____

Secondary Insurance: _____

Highest Education Level (Please circle only one):

Grade School: **1 2 3 4 5 6 7 8** High School: **9 10 11 12 GED**

Vocational School: **1 2 3** College: **1 2 3 4 4+**

All information will be kept confidential and your name/address will not be shared/sold

Authorization to Receive Diabetes Prevention Program Workshop

Consent and Release:

I _____ the undersigned hereby consent to participate voluntarily in this Diabetes Prevention Workshop which may include photographs and/or video of myself. I take full responsibility for initiating any appropriate follow-up assessment and care with my health care provider. I waive any and all rights and claims against NKFH and/or liabilities that may arise from the DPP Workshop. I further understand that the results may be used for research purposes and may be published, but any information that could result in my identification will remain confidential to the extent allowed by law.

Participant Signature: _____ ***Date:*** _____