

Diabetes Prevention Program (DPP) Provider Referral Form

Please fill out the information below and fax to HPSM at **650-829-2072** or email to HealthEducationRequest@hpsm.org.

If you have any questions, call the Health Promotion Unit at **650-616-2165**.

Member must meet the criteria [listed on our website](#).

Member information

Member's name:

Date of Birth:

Gender:

Phone:

Preferred language:

Street address:

City, State, Zip:

Additional diagnosis:

Height: feet inches

Date:

Weight: pounds Date:

Body Mass Index:

Date:

Previous type 1 or type 2 diabetes diagnosis? Yes No

Pregnant? Yes No

Diagnosed with end-stage renal disease? Yes No

Referral Date:

Member ID#:

HPSM plan: CareAdvantage

Medi-Cal

Member must meet one of the following requirements:

HbA1c Reading % Date

Fasting plasma glucose

- 100–125 mg/dL (Medi-Cal members only)

- 110–125 mg/dL (CareAdvantage members only)

Reading

mg/dL

Date

2 hour plasma glucose

Reading

mg/dL

Date

Previous gestational diabetes diagnosis (Medi-Cal members only)

Yes

No

Date of diagnosis:

Referring Provider or Facility

Provider name: First

MI

Last

Referring provider type:

Clinic:

Phone:

Fax:

Email:

Primary care provider (if different than referring provider)

Name: