

## 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](mailto: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:

Referral Date:

Date of Birth:

Gender:

Member ID#:

Phone:

Preferred language:

HPSM plan: CareAdvantage

Street address:

Medi-Cal

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

### 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: