

I CAN Prevent Diabetes Risk Questionnaire

This form will help you and 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 (this program is not for women who are pregnant)

Take the Test – Know Your Score!

Answer these seven simple questions. For each “Yes” answer, add the number of points listed. All “No” answers are 0 points.

	Yes	No
Are you a woman who has had a baby weighing more than 9 pounds at birth?	1	0
Do you have a sister or brother with diabetes?	1	0
Do you have a parent with diabetes?	1	0
Find your height on the chart on the back side. Do you weigh as much as or more than the weight listed for your height?	5	0
Are you younger than 65 years of age and get little or not exercise in a typical day?	5	0
Are you between 45 and 64 years of age?	5	0
Are you 65 years of age or older?	9	0
Total points for “yes” responses:		

Know Your Score

9 or more points: High risk for having prediabetes now. Please bring this form to your health care provider soon. You may need a blood test to find out if you have prediabetes. If they recommend a test and you complete it, then ask your doctor, nurse or dietitian to fill in the information on the back and bring this completed form, signed by your provider to enroll in a diabetes prevention program. Check www.icanpreventdiabetes.org for a group near you to help you reduce your risks for developing diabetes.

3 to 8 points: Probably not at high risk for having prediabetes now. To keep your risk level below high risk:

- If you're overweight, lose weight
- Be active most days
- Don't use tobacco
- Eat low-fat meals including fruits, vegetables, and whole-grain foods
- If you have high cholesterol or high blood pressure, talk to your health care provider about your risk for type 2 diabetes

What if I scored a “9” or higher on the test?

How can I get tested for prediabetes?

Individual or group health insurance: See your health care provider. If you don't have a provider, ask your insurance company about providers who take your insurance. Deductibles and copays may apply.

Medicaid: See your health care provider. If you don't have a provider, contact a state Medicaid office or contact your local health department.

Medicare: See your health care provider. Medicare will pay the cost of testing if the provider has a reason for testing. If you don't have a provider, contact your local health department.

No insurance: Contact your local health department for more information about where you can be tested or call your local health clinic.



CDC Diabetes Prevention Recognition Program

At-Risk Weight Chart

Height	Weight (in Pounds)
4'10"	129
4'11"	133
5'0"	138
5'1"	143
5'2"	147
5'3"	152
5'4"	157
5'5"	162
5'6"	167
5'7"	172
5'8"	177
5'9"	182
5'10"	188
5'11"	193
6'0"	199
6'1"	204
6'2"	210
6'3"	216
6'4"	221

Do you weigh more than the weight listed for your height?

Use this CDC Diabetes Prevention Recognition Program At-Risk Weight Chart to help you answer question 4 about your height and weight on the other side of this page

If you scored 9 or more points on the Take the Test – Know your Score! on the other side of this page, ask your healthcare provider if you need a test for diabetes or prediabetes.

If you have prediabetes, it does NOT mean that you have diabetes. However, you can take steps to lose 7% of your body weight (about 10 pounds) and help prevent or delay diabetes.

To enroll in a diabetes prevention program (such as I CAN Prevent Diabetes), check www.icanpreventdiabetes.org for a group near you. Bring this completed signed form to enroll.

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

- Step 1:** My patient, _____, has prediabetes or is at risk for diabetes; check all that apply
- Fasting plasma glucose = 100 -125 mg/dL **OR**
 - 2-hour (75 gm glucose) plasma glucose = 140 – 199 mg/dL
 - A1C = 5.7 – 6.4 % **OR**
 - Clinical diagnosis of Gestational Diabetes GDM during a previous pregnancy **OR**
 - Prediabetes determined using the CDC Prediabetes Screening Test on the other side

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 gradual increases in moderate physical activity and participate

In a diabetes prevention program

Step 3: _____ (Patient name) _____ (Patient phone number)
 is referred to the I CAN Prevention Diabetes Program or other Diabetes Prevention Program.

_____ **Provider signature** _____ **Date**
 _____ **Clinic**

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