|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Eligibility Criteria** | | | | | | | | | | | | | | |
| * Be aged 18 or over * Is not pregnant * Has ‘Non-Diabetic Hyperglycaemia’ (NDH) identified by blood test within 24 months of referral * Has a history of Gestational Diabetes Mellitus (GDM) and normoglycaemia | | | | | | | **Non-Diabetic Hyperglycaemia (NDH)**   1. HbA1c of 42-47mmol/mol (6.0% - 6.4%), or; 2. Fasting Plasma Glucose (FPG) of 5.5 - 6.9mmol/l   **Normoglycaemia**  HbA1c < 42 mmol/mol (< 6.0%) or FPG < 5.5mmol/l | | | | | | | |
|  | | | | | | |  | | | | | | | |
| **Essential Patient Information (Must be Fully Completed)** | | | | | | | | | | | | | | |
| **\*Patient Title** | |  | | | | | **\*NHS Number** | | |  | | | | |
| **\*Patient First Name** | |  | | | | | **\*Date of Birth** | | |  | | | | |
| **\*Patient Last Name** | |  | | | | | **\*Sex** | | |  | | | | |
|  | | | | | | | | | | | | | | |
| **\*Address** | | | | |  | | | | | | | | | |
| **\*Postcode** | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **\*Patient Contact Telephone Number (At Least One Preferred Contact Number Required)** | | | | | | | | | | | | | | |
| **Preferred Contact Number** | | | | |  | | **Alt. Contact Number** | | | | |  | | |
|  | | | | | | | | | | | | | | |
| **Patient Email Address** | | |  | | | | | | | | | | | |
| **\*Does the Patient Speak English (Y/N)** | | | | |  | | **Please State First Language** | | | | |  | | |
| **Patient’s Carer / Representative Name (If Applicable)** | | | | | | | | | |  | | | | |
| **Patient’s Carer / Representative Telephone Number (If Applicable)** | | | | | | | | | |  | | | | |
| **Consent Given to Contact Carer (Y/N)** | | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | |
| **\*Latest Blood Test Results and Date (One Required, See Eligibility Criteria)** | | | | | | | | | | | | | | |
| **HbA1c Result** |  | | | | | | **Date of HbA1c Result** | | | |  | | | |
| **FPG Result** |  | | | | | | **Date of FPG Result** | | | |  | | | |
| **Has a History of Gestational Diabetes Mellitus (GDM) and Normoglycaemia (Y/N)** | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | |
| **\*Weight Measurement (Kg)** | | | | |  | | **\*Date of Weight Measurement** | | | | | |  | |
| **\*Height (M)** | | | | |  | | **\*Referral Date** | | | | | |  | |
| **\*Patient on LD Register (Y/N)** | | | | |  | | **\*Patient on SMI Register (Y/N)** | | | | | |  | |
|  | | | | | | | | | | | | | | |
| **\*Practice Name** | | | |  | | | | | **\*Practice Code** | | | |  | |
| **\*Referral Resulting from NHS Health Check (Y/N)** | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | |
| **Patient Declaration & Consent OR HCP Referral on Behalf of Patient** | | | | | | | | | | | | | | |
| **\*This patient has consented to be contacted in all methods detailed in this form (Y/N)** | | | | | | | | | | | | | |  |
| **\*This patient has consented to this referral being submitted (Y/N)** and for selected fields of their medical record to be shared with the service provider and those organisations used by the service provider, for the purpose of managing their diabetic risk as part of this NHS DPP Programme | | | | | | | | | | | | | |  |
| **MUST BE COMPLETED IF PERSON REFERRED IS AGED OVER 80 YEARS: This programme is likely to result in weight loss. Do you consider the benefits of this programme are likely to outweigh the potential risks for this individual? (Y/N)**  (Please note that weight loss may cause or exacerbate sarcopenia even if there is co-existent obesity, leading to functional decline and risk of falls, and this risk is elevated in older people or those with frailty). | | | | | | | | | | | | | |  |
| **\*Preferred Service Pathway (Mark Options as Appropriate)** | | | | | | | | | | | | | | |
| **Group sessions** | | | |  | | **Digital App Coaching** | |  | | **Not sure** | | | |  |

**Your NHS Diabetes Prevention Programme provider is Living Well Taking Control. They will make a first contact attempt with your patient within 5 days of receiving this referral form.**

**Please send this referral form to:** [**hex.ndpp.nn@nhs.net**](mailto:hex.ndpp.nn@nhs.net)