



Recommendation Form for the
National Diabetes Prevention Program

This is a recommendation for an adult patient to participate in the lifestyle change program recognized or pending recognition by the Centers for Disease Control and Prevention as a part of the National Diabetes Prevention Program.

I am recommending: _____
(First Name) (MI) (Last Name)

enroll in the National Diabetes Prevention Program lifestyle change program based on the following eligibility criteria:

- ☐ 18 years or older
- ☐ BMI ≥ 24 kg/m² (≥ 22 if Asian)
- ☐ Diagnosis of prediabetes or GDM based on (check one or more)
 - ☐ Fasting blood glucose (range 100-125 mg/dl)
 - ☐ 2-hour glucose (range 140-199 mg/dl)
 - ☐ HbA1c (range 5.7-6.4)
 - ☐ Previous GDM (may be self-reported)

Health Care Provider Information

Signature: _____ Date: _____

Name: _____

Address: _____

Phone: _____

*Make a copy and provide the completed form to the patient, who may contact this local program for more information and to enroll:



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