GHS Employee & Dependent DPP Enrollment Form

Please fill out Sections 1 & 2 and scan the form to dpp@ghs.org to enroll in the Diabetes Prevention Program.

Section 1: **Today's Date** *(mm/dd/yyyy)*: _____

First Name:	**Last Name:**
E-mail Address:	**Phone Number**: _____-_____-_____
Preferred contact method *(check all that apply):* ☐ Phone call ☐ Email ☐ Text message	**Please list cellular phone carrier:**
Date of Birth *(mm/dd/yyyy)*: _____/_____/_____	**Gender** *(check one)*: ☐ Male ☐ Female
State of Residency:	**Ethnicity** (*check one*): ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (*check all that apply):* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	**Highest Level of Education** *(check one)*: ☐ Less than grade 12 ☐ Grade 12 or GED ☐ College - 1 year to 3 years (some college or technical school) ☐ College – 4 years or more
Height: _____ feet _____ inches	**Starting Weight** *(self-reported):* _____ pounds *(round to nearest pound)*
Preferred program location(*check all that apply):* ☐ Easley ☐ Laurens ☐ Greenville ☐ Oconee ☐ Greer ☐ Simpsonville	**Please select from the following:** ☐ GHS employee; Employee ID #: _____ ☐ Dependent of GHS employee *If dependent, list name of employee below:* _____

How did you learn about this program?	**Are you on the GHS Health Plan?**
☐ Non-primary care health professional ☐ Primary care provider/office or specialist ☐ Community-based organization or community health worker ☐ Self (decided to come on own)Family/friends ☐ An employer or employer's wellness program ☐ Insurance company ☐ Media (poster/flyer, website, etc.) ☐ Other ☐ Not reported	☐ Yes ☐ No If no, then who is your insurance provider? _____

Section 2:

1. **Have you been told by a health care provider that you have prediabetes, elevated blood sugar, or borderline diabetes?** *(check one*):

   ☐ Yes ☐ No

   1a. <u>If yes</u>, what type of blood test was performed? *(check all that apply)*

   - ☐ Finger prick blood test
   - ☐ Fasting glucose test (blood test where blood was drawn with needle)
   - ☐ Hemoglobin A1c test
   - ☐ Oral Glucose Tolerance Test
   - ☐ Don't know / don't remember

   1b. <u>If no,</u> complete the Prediabetes Risk Test.

2. **Do you have a primary care provider?**

   ☐ Yes ☐ No

   <u>If yes</u>, who is your provider and what is the name of the provider's practice?

   _____

3. **<u>If you are a woman</u>, have you ever been told by a health care provider that you had Gestational Diabetes Mellitus (GDM) during pregnancy?** *(check one*):

   ☐ Yes ☐ No

4. **<u>If you are a woman</u>, are you pregnant or planning to become pregnant?** *(check all that apply*):

   ☐ Yes ☐ No ☐ Planning to become pregnant

For Lifestyle Coach Use only

Risk Test Score:	**Location Selected:**
Eligible: ☐ Yes ☐ No	**Lifestyle Coach Assigned:**