WESTPORT WESTON HEALTH DISTRICT
180 Bayberry Lane, Westport, CT 06880-2855
Telephone: (203) 227-9571 Telefax (203) 221-7199

DIABETES REGISTRATION FORM

Patient Name: _____ **Daytime Tel:** _____ **Date of Birth:** _____

Address: _____

Town: _____ **State:**_____ **Zip Code:** _____ **Male** ☐ **Female** ☐

Do you have diabetes?	☐yes	☐no
If so, do you check your blood sugar?	☐yes	☐no
Do you have a family history of diabetes?	☐yes	☐no
Are you pregnant?	☐yes	☐no
Are you more than 30% overweight?	☐yes	☐no
Do you exercise regularly?	☐yes	☐no
Are you African American, Hispanic, or American Indian?	☐yes	☐no
Have you had gestational diabetes or delivered a baby over 9 lbs?	☐yes	☐no

Physician: _____

Address: _____ **Town:** _____ **State:**_____ **Zip:** _____

CONSENT AND RELEASE FOR SCREENING:

I hereby consent to the drawing and testing of a blood sample for screening purposes. I hereby release the Westport Weston Health District from any and all liability arising from or in any way connected with this procedure. I understand that this is a screening test and that any information received does not constitute a diagnosis of any kind. I also understand that the responsibility for initiating a follow-up examination to confirm the results and obtain advise and treatment is mine and not that of the organization associated with this screening.

Signature: _____ Date: _____

Screener: _____ Date: _____ Screening Site: _____

WHOLE BLOOD TEST	YOUR RESULT	NEGATIVE SCREEN	"PRE-DIABETES" (Impaired Glucose)	DIABETES*
FASTING GLUCOSE		<100 mg/dl	100 – 125 mg/dl	≥ 126 mg/dl
2 HR AFTER EATING		<140 mg/dl	140 - 199 mg/dl	≥ 200 mg/dl
RANDOM				≥ 200 mg/dl

Recommendation: Referral for medical evaluation ____ Nutritional evaluation _____
Repeat screening on another day ____ Exercise ____

Date of follow-up contact _____ Received further evaluation yes ☐ no ☐ Result _____