Challenge Diabetes Program

In participation with the YMCA of Greater Springfield

Basic Information Form

Dear Health Care Professional,
Your patient is participating in a program that discusses diabetes and provides peer support.

Please ensure the patient knows:

- Whether their medication can cause hypoglycemia
- If so, the symptoms and treatment of hypoglycemia
- Any physical limitation(s)

CDP challenges diabetics to lower their A1cs and they receive a reward if they succeed. We ask you to report their last A1c before the program and the first at least three months after. At that time CDP will send the HCP a copy of this form and a request for the second A1c.

Health Care Professional and Participant agree to report the two A1cs for this purpose.

_____ _____ _____
HCP Signature **Printed HCP Name** **Date**

_____
HCP City/Town

_____ _____ _____
Participant Signature **Printed Participant Name** **Date**

_____ _____ _____
Participant email **Participant Phone #**

_____
Participant Address

Last A1c _____ Date of test _____

This form contains <u>confidential information</u> that must be returned in one of these ways:

- Email it to coordinator@challengediabetes.us
- Fax it to CDP, Att: Coordinator 413-567-5734
- Mail it to CDP, P.O. Box 4655, Springfield, MA 01101
- Bring it to any CDP session

Do not drop off or mail it to the YMCA