MAKE A CHANGE. START TODAY!
Take the “Could You Have Prediabetes?” quiz on the inside of this brochure. If your score shows you are at high risk for prediabetes:

1. TAKE THIS BROCHURE TO YOUR HEALTH CARE PROVIDER.
2. ASK TO BE TESTED FOR PREDIABETES. THIS IS A SIMPLE BLOOD TEST.
3. ASK YOUR HEALTH CARE PROVIDER TO FILL OUT THE RECOMMENDATION FORM.
4. TAKE THE COMPLETED FORM TO A PROGRAM NEAR YOU. TO FIND A PROGRAM, CALL US TODAY.
5. IF YOU DON’T HAVE A HEALTH CARE PROVIDER, CALL US TO FIND OUT IF YOU QUALIFY FOR THE PROGRAM.

WITH THE BIENESTAR DIABETES PREVENTION PROGRAM YOU GET:

- A CDC-approved curriculum
- The skills you need to lose weight, be more physically active, and manage stress
- A trained lifestyle coach to guide and encourage you
- Support from other participants with the same goals as you
- 16 weekly sessions
- 6 monthly follow-up sessions to help you maintain healthy lifestyle changes
- Exercise classes

The Bienestar Diabetes Prevention Program is part of the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC). The Bienestar program is organized by the University of Colorado Anschutz Health and Wellness Center in collaboration with CREA Results.

The Bienestar Diabetes Prevention Program is in your community and may be available at no cost to you!

FOR PROGRAM INFORMATION, PLEASE CALL 720-255-5465

You can prevent diabetes.
RECOMMENDATION FORM

Take this form to your health care provider, then take the completed form to a Bienestar Diabetes Prevention Program near you.

I RECOMMEND THAT MY PATIENT, ____________________________ (FIRST NAME) ____________________________ (MI) ____________________________ (LAST NAME),

PARTICIPATE IN THE BIENESTAR DIABETES PREVENTION PROGRAM BASED ON THE FOLLOWING ELIGIBILITY CRITERIA:

1. 18 YEARS OR OLDER BMI ≥ 25 KG/M² (≥ 22 IF ASIAN)
2. 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)
   - hBAIC (RANGE 5.7%–6.4%)
   - PREVIOUS GDM (MAY BE SELF-REPORTED)

PROVIDER SIGNATURE ____________________________ (DATE)__________________________

PROVIDER NAME: ____________________________

ADDRESS: ____________________________

PHONE: ____________________________

MAKE A COPY AND GIVE THE COMPLETED FORM TO THE PATIENT, WHO MAY CONTACT THE BIENESTAR PROGRAM FOR MORE INFORMATION AND TO ENROLL.

BIENESTAR DIABETES PREVENTION PROGRAM

720-255-5465