Sun Health™ WELLNESS

# Prediabetes Risk Test

NATIONAL DIABETES PREVENTION PROGRAM

**1. How old are you?**

Write your score in the boxes below

Younger than 40 years (0 points)
40–49 years (1 point)
50–59 years (2 points)
60 years or older (3 points)

**2. Are you a man or a woman?**

Man (1 point) Woman (0 points)

**3. If you are a woman, have you ever been diagnosed with gestational diabetes?**

Yes (1 point) No (0 points)

**4. Do you have a mother, father, sister, or brother with diabetes?**

Yes (1 point) No (0 points)

**5. Have you ever been diagnosed with high blood pressure?**

Yes (1 point) No (0 points)

**6. Are you physically active?**

Yes (0 points) No (1 point)

**7. What is your weight category?**

(See chart at right)

**Total score:**

| Height | Weight (lbs.) | | |
|---|---|---|---|
| 4'10" | 119-142 | 143-190 | 191+ |
| 4'11" | 124-147 | 148-197 | 198+ |
| 5'0" | 128-152 | 153-203 | 204+ |
| 5'1" | 132-157 | 158-210 | 211+ |
| 5'2" | 136-163 | 164-217 | 218+ |
| 5'3" | 141-168 | 169-224 | 225+ |
| 5'4" | 145-173 | 174-231 | 232+ |
| 5'5" | 150-179 | 180-239 | 240+ |
| 5'6" | 155-185 | 186-246 | 247+ |
| 5'7" | 159-190 | 191-254 | 255+ |
| 5'8" | 164-196 | 197-261 | 262+ |
| 5'9" | 169-202 | 203-269 | 270+ |
| 5'10" | 174-208 | 209-277 | 278+ |
| 5'11" | 179-214 | 215-285 | 286+ |
| 6'0" | 184-220 | 221-293 | 294+ |
| 6'1" | 189-226 | 227-301 | 302+ |
| 6'2" | 194-232 | 233-310 | 311+ |
| 6'3" | 200-239 | 240-318 | 319+ |
| 6'4" | 205-245 | 246-327 | 328+ |
| | 1 Point | 2 Points | 3 Points |
| | *You weigh less than the 1 Point column (0 points)* | | |

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009. Original algorithm was validated without gestational diabetes as part of the model.

## If you scored 5 or higher

You are at increased risk for having prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you have type 2 diabetes or prediabetes, a condition in which blood sugar levels are higher than normal but not high enough yet to be diagnosed as type 2 diabetes. **Talk to your doctor to see if additional testing is needed.**

*If you are African American, Hispanic/Latino American, American Indian/Alaska Native, Asian American, or Pacific Islander, you are at higher risk for prediabetes and type 2 diabetes. Also, if you are Asian American, you are at increased risk for type 2 diabetes at a lower weight (about 15 pounds lower than weights in the 1 Point column). Talk to your doctor to see if you should have your blood sugar tested.*

14719 W. Grand Avenue, Surprise, AZ 85374
Mail: PO Box 6030, Sun City West, AZ 85376
(623) 471-9355
SunHealthWellness.org

# Diabetes Prevention Program Screening Test

Date _____

Name (Last, First, MI) _____ Current Age _____

Gender _____ Height _____ Weight _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Reported

Race:

☐ Black or African American ☐ Asian or Asian American ☐ America Indian or Alaska Native

☐ Native Hawaiian ☐ Pacific Islander ☐ White

Education:

☐ Less than grade 12 ☐ High School diploma or GED ☐ Some College (1-3 years)

☐ College Graduate ☐ Not Reported

Was your prediabetes diagnosed by a blood test? ☐ Yes ☐ No

If Yes, please indicate which type of test and the value:

☐ Elevated Fasting Glucose _____

☐ Elevated Oral Glucose Tolerance Test _____

☐ Elevated A1c _____

☐ Lab results unknown or labs did not show prediabetes

Do you have a history of Gestational Diabetes? ☐ Yes ☐ No

Office Use Only:

Referral Source: _____

14719 W. Grand Avenue
Surprise, AZ 85374

SunHealthWellness.org



Phone: (623) 471-9355
Fax: (623) 213-8523

Sun Health WELLNESS

# New Client Intake Form

Date

Name _____ Date of Birth _____

Gender _____ Marital Status _____ Occupation _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Email Address _____

Emergency Contact Name _____ Phone # _____

Primary Care Doctor _____ Phone # _____

Referring Doctor, if applicable _____ Phone # _____

1st Insurance Company and Policy # _____ 2nd Insurance Company and Policy # _____

## MEDICATIONS

Please list all medications, vitamins, minerals, or herbal supplements that you are taking, including the dose. (if additional space is needed, please include separate sheet.)

| | | |
|---|---|---|
| | | |
| | | |
| | | |

## MEDICAL HISTORY

Please check all that apply to your current situation.

- Anemia
- Anxiety
- Balance Issues
- Bleeding Disorder
- Cancer
- Chronic Pain
- Constipation
- Depression
- Diabetes
- Diarrhea/Loose Stools
- Gallbladder Disease
- GERD
- Gout
- Heart Disease
- Hiatal Hernia
- High Blood Pressure
- High Cholesterol, High Triglycerides, High LDL / Low HDL (dyslipidemia)
- IBS
- Injury to Bones/Muscle
- Joint Disease
- Liver Disease
- Lung Disease, SOB, Asthma, Emphysema, COPD
- Memory Issues
- Osteoporosis
- Overweight
- Pre-Diabetes
- Recent Surgeries
- Stroke/TIA
- Thyroid Disorder
- Underweight
- Unexplained Mental Decline
- Urinary/Kidney Disease

Name: DOB:

Current Height: _____ Current Weight: _____

**List Allergies (medication, environmental, food, etc.)**

Updated: May 2015

Sun Health WELLNESS

# Client Consent and Acknowledgement

Name: _____ Date of Birth:_____

Please read and initial each section:

_____ **Financial Responsibility**: I do hereby guarantee payment of therapy services to Sun Health Center for Health & Wellbeing (CHW). I understand that I am responsible for payment of my account and the CHW does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, CHW will bill my insurance. I understand that co-payments are due when services are rendered. Any balance, after the insurance payment has been received, is due and payable upon receipt. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

_____ **Consent for Consultation**: I hereby consent to the consultation services of CHW staff.

_____ **Authorization for Release of Information**: The CHW is hereby authorized to furnish and release, in accordance with the CHW policy and HIPAA guidelines, such professional and clinical information as may be necessary for the completion of my medical claims. The CHW is hereby released from all legal liability that may arise from the release of said information.

_____ **Assignments and Authorization to Pay Insurance Benefits**: I hereby assign and authorize payment directly to Sun Health/CHW, herein specified and otherwise payable directly to me, but not to exceed the CHW's regular charges for this period of service. I understand I am responsible to the services charges not covered or paid by my insurance.

_____**Assignments and Authorization to Bill Medicare**: I hereby assign and authorized payment directly to Sun Health/CHW, herein specified and otherwise payable to me, but not exceed CHW's regular charges for this period treatment. I understand I am financially responsible for any charges not covered under Medicare Part B coverage.

_____**Client Rights & Responsibilities**: I have received a copy of CHW's Client Rights & Responsibilities.

_____ **Notice of Privacy Practices (HIPAA)**: I have received a copy of CHW's Notice of Privacy Practices.

**Client and/or Responsible Party agree and have received a copy of this document.**

_____ Date:_____
Client Signature

_____ Date:_____
Responsible Party Signature (if applicable)

_____ Date:_____
Facility Witness

14719 W. Grand Avenue
Surprise, AZ 85374

SunHealthWellness.org

Phone: (623) 471-9355
Fax: (623) 213-8523

Welcome to Sun Health Center for Health & Wellbeing! We are here to assist you in learning strategies to improve your health and to live well with chronic disease. We appreciate you placing your trust in us to assist you in your wellness journey.

## Client Rights & Responsibilities

Sun Health Center for Health & Wellbeing (CHW) shall provide to all clients certain rights which apply without regard to race, color, religion, gender, sexual orientation, national origin or disability. These rights cover conditions, benefits and privileges on an equal opportunity basis. This document summarizes specific rights you have as a client, as provided by Federal and Arizona state statutes and rules, as well as specific responsibilities that you bear.

### Your Rights:

1. You have the right to be treated with respect and dignity, in recognition of your individuality and preferences.
2. You have the right to quality care and treatment that is fair and free from discrimination.
3. Relatives or a legal representative may act on your behalf to exercise these rights when you are unable to do so yourself.
4. You have the right to:
    a. Privacy in treatment and personal care needs
    b. Be free from the intentional infliction of physical, mental, or emotional harm, exploitation, restraints, and sexual abuse/assault. You will be free of neglect, coercion, manipulation, and seclusion.
    c. Consent to treatment before the treatment is initiated and you have the right to refuse or to withdraw your consent for treatment(s).
    d. Receive information about Health Care Directives and participate in decisions concerning program participation.
    e. Be provided information about submitting a grievance or concern. You will not be retaliated against for submitting a complaint.
    f. Information about proposed treatments/procedures, alternatives, risks, and possible complications.
    g. Upon written request, a copy of your medical records within two business days of request.

### Your Responsibilities:

1. You are responsible for providing a complete and accurate medical history, and for providing information about unexpected complications that may arise. You are also responsible for making it known whether or not you clearly comprehend a contemplated course of action and the things that you are expected to do.
2. The Sun Health CHW is located in a tobacco-free building. You must agree and understand that the use of tobacco products is prohibited in any area surrounding this building. We may refuse to serve a client who refuses to comply with this policy, as it is endangering the health of other clients and staff members,
3. You have the responsibility of providing accurate information necessary for the facility to process bills and the obligation to arrange for the payment of those bills.
4. You have the responsibility to be considerate to all facility personnel and to other clients by:
    a. Treating our staff and other clients with respect and refraining from disruptive or abusive behavior.
    b. Arriving on time for your appointment.
    c. cancelling or modifying appointment times with staff with at least 24 hours' notice.
    d. Parking in designated areas in the north or south lots of the CHW building.
    e. Assuring that your accompanying visitor(s) be considerate of other clients and facility personnel. This includes ensuring privacy during treatments, both visually and verbally as well as refraining from any type of electronic recording on the campus.

   f. Reminding visitors to observe smoking regulations.
   g. Being respectful of religious, cultural and medical differences of other client/clients.
5. You have the responsibility to bring concerns and / or grievances to the attention of the Administrator or to the Department of Health Services.
6. You are responsible for your own valuables and you are strongly encouraged to leave valuables home.
7. You are responsible for using facility services, supplies and equipment appropriately and economically in order to assure the availability to our other clients. You will be held financially responsible for any deliberate damage to facility equipment or property.

We reserve the right to refuse service to anyone, including when clients fail to comply with CHW policies or to uphold the responsibilities noted above.

## Contact Us

Sun Health Center for Health & Wellbeing
14719 West Grand Avenue
Surprise, Arizona 85374
(623) 471-9355

## Hours of Operation

Monday –Friday
8:30 AM- 5:00 PM

## Concerns/Grievances

While you are a client here at CHW, we will do our best to meet your needs. If you believe we have not met your needs or expectations, we would sincerely like to discuss your concern. Please contact the staff you are working with or the administrator at (623) 832-9355 to address these concerns.

- Concerns regarding any aspect of CHW may be submitted either orally or in writing, by anyone.
- When filing a concern, you are encouraged to speak with a staff member or the administrator. The CHW maintains an "open door" policy.
- If your verbalized concern is not resolved timely and to your satisfaction, any staff member will assist you in completing a written concern, if requested.
- All written concerns will be investigated promptly by administrative personnel and the results will be made available to you within thirty (30) days.
- If you remain unsatisfied with the result/resolution of the concern, you may file a grievance with the Arizona Department of Health Services. Contact phone numbers are listed below and more procedures for this process are available for public inspection posted in the center lobby.

Arizona Department of Health Services
150 North 18th Avenue, 4th floor
Phoenix, Arizona 85007 602-364-2536

## Notice of Privacy Practices (HIPAA)

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

We are committed to protecting the confidentiality of your medical information and are required by law to do so. This notice describes how we may use your medical information within Sun Health Center for Health & Wellbeing (CHW) and how we may disclose it to others outside of CHW. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

**How will we use and disclose your medical information?**

**Treatment:** We may use your medical information to provide you with medical services and supplies. We also may disclose your medical information to others who need that information to treat you, such as physicians, physician assistants, nurse practitioners, nurses, medical and nursing students, technicians, therapists, emergency services and medical transportation providers, medical equipment providers and others involved in your care. We may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

**Family Members and Others Involved in Your Care:** Medical information to a family member or friend who is involved in your medical care or to someone who helps to pay for your care may only be disclosed with your consent. If you do not want CHW to disclose your medical information to family members or others, please notify staff anytime during your visit. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster.

**Payment:** We may use and disclose your medical information to obtain payment for the medical services and supplies we provide to you. For example, your health plan or health insurance company may ask to see part of your medical record before they will pay us for your treatment.

**Facility Operations:** We may use and disclose your medical information if it is necessary to improve the quality of care we provide to clients or to run the operations of the CHW. We may use your medical information to conduct quality-improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate whether CHW personnel, your doctors or other healthcare professionals did a good job.

**Research:** We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you receive. These research projects must go through a special process that protects the confidentiality of your medical information.

**Required by Law:** Federal, state, and local laws sometimes require us to disclose clients' medical information. For instance, we are required to report abuse or neglect and must provide certain information to law-enforcement officials in domestic-violence cases. We also are required to give information to the Arizona Workers' Compensation Program for work related injuries.

**Public Health:** We may report certain medical information for public health purposes. For example, we are required to report deaths and communicable diseases to the State of Arizona. We also may need to report clients' problems with medication or medical products to the FDA or notify clients of recalls of products they are using.

**Public Safety:** We may disclose medical information for public-safety purposes in limited circumstances. We may disclose medical information to law-enforcement officials in response to a search warrant or a grand-jury subpoena. We also may disclose medical information to assist law-enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct and to report criminal conduct at the CHW. We also may disclose your medical information to law-enforcement officials and others to prevent a serious threat to health or safety.

**Health-Oversight Activities:** We may disclose medical information to a government agency that oversees CHW and our personnel, such as the Arizona Department of Health Services, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the facility's compliance with state and federal laws.

**Military, Veterans, National Security and Other Government Purposes:** If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. CHW may also disclose medical information to federal officials for intelligence and national-security purposes or for Presidential Protective Services.

**Judicial Proceedings:** CHW may disclose medical information if the facility is ordered to do so by a court or if the facility receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so you will have a chance to object to sharing your medical information.

**Information with Additional Protection:** Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable diseases and HIV/AIDS, drug and alcohol-abuse treatment for a serious mental illness is treated differently than other types of information. For those types of information, CHW is required to obtain your permission before disclosing that information to others in many circumstances.

**Other Uses and Disclosures:** If CHW wishes to use or disclose your medical information for a purpose that is not discussed in this notice; the facility will seek your permission. If you give your permission to CHW, you may take back that permission at any time, unless we already have relied on your permission to use or disclose the information. If you ever would like to revoke your permission, please notify the CHW staff in writing.

## Your HIPAA Rights

**Right to Request Your Medical Information:** You have the right to look at your own medical information and to secure a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record and other records we use to make decisions about your care. To request your medical information, write to CHW, 14719 W. Grand Ave., Surprise, AZ 85374. You may call (623) 832-9355 for additional information. If you request a copy of your records, we may charge you for our costs to copy the information. We will tell you in advance what the cost will be. Please allow at least 48 business hours for this request.

**Right to Request Amendment of Medical Information You Believe is Erroneous or Incomplete:** If you examine your medical information and believe some of the information is wrong or incomplete, you may ask to amend your record. For information about amending your medical record information, contact the CHW at the address or phone number listed above.

**Right to Get a List of Certain Disclosures of Your Medical Information:** You have the right to request a list of any disclosures we make of your medical information. If you would like to receive such a list, contact the CHW

as listed above. We will provide the first list to you free but we may charge you for any additional lists you request during the same twelve-month period. We will tell you in advance what this will cost.

**Right to Request Restrictions on How CHW Will Use or Disclose Your Medical Information for Treatment, Payment or Healthcare Operations:** You have the right to ask us not to make uses or disclosures of your medical information to treat you, to seek payment for care or to operate the CHW. We are not required to agree to your request. If you want to request a restriction, write to CHW, at the aforementioned address and describe your request in detail.

**Right to Request Confidential Communication:** You have the right to ask us to communicate with you in a way you feel is confidential. For example, you can ask us not to call your home or to communicate only by mail. To do this, please contact front office staff during your visit. The office staff can be reached by calling (623) 832-9355.

**Changes to this notice:**
From time to time, we may change our practices concerning how we use or disclose client medical information or how we will implement client rights concerning protected health information. We reserve the right to change this notice and to make the provisions in our new notice effective for all medical information we maintain. If we change these practices, you can obtain an updated copy from CHW by calling (623) 832-9355.

**Which healthcare providers are covered by this notice?**
This Notice of Privacy Practices applies to CHW and all personnel, contractors, volunteers, students and trainees. The notice also applies to other providers who come to CHW to care for clients. These providers may include physicians, physician assistants, nurse practitioners, therapists and other healthcare providers not employed by CHW, unless these other healthcare providers give you their own notice that describes how they will protect your medical information. CHW may share your medical information with these other healthcare providers for their treatment purposes, to obtain payment for treatment or to conduct healthcare operations. This arrangement is only for sharing information and does not create any affiliation with these other providers. Other healthcare providers also have their own Notices of Privacy Practices that apply to their offices and facilities.

**Do you have concerns or complaints?**
Please tell us about any problems or concerns you have with your privacy rights or how CHW uses or discloses your medical information. If you have a concern, please contact CHW in writing at 14719 W. Grand Ave., Surprise, AZ 85374, or by telephone at (623) 832-9355. If CHW cannot resolve your concern, you may file a complaint with the Department of Health and Human Services Office for Civil Rights. We will not penalize you or retaliate against you in any way for filing a complaint with the Office for Civil Rights. Contact them via the internet or at: Office for Civil Rights, DHHS, and 90 7th Street, Suite 4- 100, San Francisco, CA 94103. Phone (415) 437-8310, (415) 437-8311 (TDD), Fax (415) 437-8329.

Updated: November 2017