Metabolic Syndrome
SUPPLEMENTAL TEMPLATES

These templates were drafted for DMH agencies to possibly use with clients and staff as they implement the metabolic screening, and can be modified to the extent the agency would like to use them.

- Metabolic Screening Patient Flyer
- Metabolic Screening Participant Form (optional for adults)
- Metabolic Screening Patient Results for Adult and Child
- Metabolic Screening Fax Referral Letter to Primary Care Providers
Diabetes is a disease that keeps your body from turning the food you eat into the energy you need. If left untreated, diabetes can cause severe harm to your eyes and feet. It can also lead to heart and kidney disease, which is life-threatening.

Pre-diabetes can be managed to prevent type 2 diabetes from developing. A simple blood glucose test can identify your risk of developing diabetes, and allow you to take steps to prevent it.

As part of a statewide Disease Management Initiative

Your community mental health center will screen for pre-diabetes in people at risk for developing this disease. Starting January 1, 2010 this screening will be offered to qualified clients participating in a community psychiatric rehab program. The Department of Mental Health and your community mental health center is providing this screening as part of a statewide movement to promote healthy living.

For more information about pre-diabetes, complications and treatment visit the American Diabetes Association at www.diabetes.org.
The pre-diabetes screening is **FAST** and **SIMPLE**. There are only a few things that are checked...

- Vitals (height, weight, waist circumference)
- Blood pressure
- Blood glucose levels (finger stick blood draw)
- Cholesterol levels

A qualified nurse from your community mental health center will assist you in getting the lab data necessary to determine if you are at risk for developing diabetes. These tests may be administered at a local physician’s office or at your community mental health center.

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**PARTICIPANT / GUARDIAN CONSENT**

Participant Name: 

☐ YES! I give permission for the participant named above to be screened for pre-diabetes.

________________________________________________________

Participant / Guardian Signature Date

Name Printed

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**OPT-OUT NOTICE**

Participant Name: 

☐ No, I do not wish to be screened for pre-diabetes.

________________________________________________________

Participant/Guardian Signature Date

Signature of Witness:

________________________________________________________

[agency Logo]
Congratulations, ________________ on taking an important step to managing your health care!

A qualified nurse will help you understand the results of your labs completed on ________________ (date).

<table>
<thead>
<tr>
<th>Your</th>
<th>Height is</th>
<th>__________ (inches)</th>
<th>* If your BMI is under 25, you should be monitored once a year.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weight is</td>
<td>__________ (pounds)</td>
<td>* If your BMI is over 25, then please make an appointment with your primary care physician for education on weight management and exercise.</td>
</tr>
<tr>
<td></td>
<td>BMI is</td>
<td>__________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your</th>
<th>Waist Circumference is</th>
<th>__________ (inches)</th>
<th>* Men with a waist circumference under 40, and women under 35, should be monitored 4 times a year.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>* If your waist circumference is over 40 for men or over 35 for women, then please make an appointment with your primary care physician for education on weight management and exercise.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your</th>
<th>Blood Pressure is</th>
<th>__________</th>
<th>* If your blood pressure is below 130/85, then you should be monitored once a year.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>* If your blood pressure is above 130/85, then please make an appointment with your primary care physician for follow up care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your</th>
<th>Fasting blood sugar is</th>
<th>__________</th>
<th>* If your fasting blood sugar is below 100, then you should be monitored once a year.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>* If your fasting blood sugar is between 100 and 125, you will need to be monitored 4 times a year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* If your fasting blood sugar is above 125, then please make an appointment with your primary care physician for follow up care.</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin A1c is</td>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

Your Lipid Panel Results are:

<table>
<thead>
<tr>
<th>Total Cholesterol</th>
<th>________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triglycerides</td>
<td>________________</td>
</tr>
<tr>
<td>LDL</td>
<td>________________</td>
</tr>
<tr>
<td>HDL</td>
<td>________________</td>
</tr>
</tbody>
</table>

* If your LDL is below 130, HDL above 40 and Triglycerides below 150, then you should be monitored once a year. |

* If your LDL is above 130, HDL is below 40 and Triglycerides are above 150, then please make an appointment with your primary care physician for follow up care.
**pre-diabetes**

**SCREENING RESULTS**

**Congratulations on helping your children take an important step to managing their health care!**

A qualified nurse will help you understand the results of the labs completed on ____________ (date) for ____________________________ (name).

### Under 10 years of age

- If your weight percentile is under 90%, you should be monitored 4 times a year.
- If your weight percentile is over 90%, then please make an appointment with your primary care physician for education on weight management and exercise.

### 10-17 years of age

- If your weight percentile is under 85% for age and gender, you should be monitored 4 times a year.
- If your weight percentile is over 85% for age and gender, then please make an appointment with your primary care physician for education on weight management and exercise.

### Your
- **Height** is ________ (inches)
- **Weight** is ________ (pounds)
- **BMI** is ________

### Men with a waist circumference under 40, and women under 35, should be monitored 4 times a year.

### If your waist circumference is over 40 for men or over 35 for women, then please make an appointment with your primary care physician for education on weight management and exercise.

### Your
- **Waist Circumference** is ________ (inches)

### If your blood pressure is below 130/85, then you should be monitored once a year.

### If your blood pressure is above 130/85, then please make an appointment with your primary care physician for follow up care.

### Your
- **Blood Pressure** is ___________

### If your fasting blood sugar is below 100, then you should be monitored once a year.

### If your fasting blood sugar is between 100 and 125, you will need to be monitored 4 times a year.

### If your fasting blood sugar is above 125, then please make an appointment with your primary care physician for follow up care.

### Your Lipid Panel Results are:
- **Total Cholesterol** ___________
- **Triglycerides** ___________
- **LDL** ___________
- **HDL** ___________

### * If your LDL is below 130, HDL above 40 and Triglycerides below 150, then you should be monitored once a year.

### * If your LDL is above 130, HDL is below 40 and Triglycerides are above 150, then please make an appointment with your primary care physician for follow up care.
For:  As of January 2010, the Dept. of Mental Health issued a new policy that requires mental health agencies to screen clients for metabolic syndrome in effort to reduce the mortality gap of this population due to preventable and treatable chronic diseases such as diabetes.  [agency name] has screened the patient above for metabolic syndrome.  Their lab results, recorded on attached screening form, indicates that this patient is at risk, or has results indicating possible diabetes according to the MO state screening guidelines for Pre-Diabetes & Diabetes, and this patient needs immediate follow-up with a primary care physician.

Referring provider signature

Patient Appointment Preference: (circled below)  □ No Preference
Monday  Tuesday  Wednesday  Thursday  Friday    AM or PM

Fax Submitted By: ______________________________________
Phone #:  ________________________
Fax #:  ________________________