FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA's DIABETES PREVENTION PROGRAM REFERRAL FORM

SHASTA FAMILY YMCA

Patient Name: ____

Date of Birth: ______________ Phone: __________________ E-mail:________________________

English speaking? _____ Spanish speaking? _______ Other? _____________________________

To qualify participants must:

- Be at least 18 years of age;
- Have a Body Mass Index of ≥25, or ≥22 (if Asian); and
- Have pre-diabetes as verified by blood test

********To be completed by health care provider*******

Body Mass Index

Height: ______ in Weight: ______ lbs. BMI: _____ kg/m (Must be ≥25, or ≥ 22 if Asian)

Male: ______ Female: ______

Pre-Diabetes Information (check all that apply **AND** enter value):

_____ Fasting plasma glucose (FPG) ________ mg/dL (100-125 mg/dL) **or**

_____ 2- hour plasma glucose (OGTT) ________ mg/dL (140-199 mg/dL) **or**

_____ Hemoglobin A1C ___________ % (5.7%-6.4%)

Participation Information (check one)

I _____ DO _____ DO NOT recommend that this patient participate in the YMCA's Diabetes Prevention Program where he/she will set goals to achieve a 7% weight reduction through changes in nutrition and physical activity (up to 150 minutes per week – equivalent to brisk walking).

I _____ DID obtain patient authorization to release this information to the YMCA

(please complete second page).

AUTHORIZATION TO RELEASE HEALTH INFORMATION.

Provider Name: ________________________________ Practice Name: ____________________

Provider Signature: _____________________________________ Date: _________________

Practice Contact: _______________________ Phone: _________________/Fax: _____________

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

****To Be Completed by Patient****

I agree and request that the health information on the front of this form be released to the SHASTA FAMILY YMCA for the purpose of referring me to the YMCA's Diabetes Prevention Program. I have the right to revoke this authorization at any time by writing to the health care provider named on the YMCA's Diabetes Prevention Program Referral form, except to the extent that the action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. I further understand that my treatment, payment, enrollment in a health plan, and or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

Patient name (print): ____

Signature: ____

Date: ____________________________

Thank you for your referral!
Give this form to your patient to bring to the YMCA
Questions? Call us at 530-786-2185, or email ymcadpp@sfymca.org