Physician Referral Form

☐ **I am referring my patient to the following YMCA program(s).**

☐ YMCA Diabetes Prevention Program (for those with pre-diabetes)

One-year program to help adults reduce their risk of converting to full diabetes by learning about physical activity and nutrition leading to weight loss and risk reduction. **Who is eligible? For Active adult members age 18 years or older, Adult members at risk for diabetes, Adult members with a BMI equal to or greater than 25, Adult members with an A1C between 5.7% - 6.4%.**

☐ Blood Pressure Self-Monitoring Program (BPSM)

Adults: 4-month program. Participants measure their blood pressure twice a month, attend two personalized consultations per month and attend monthly nutrition seminars. **Who is eligible? 18 years or older and have been diagnosed with high blood pressure. Participants cannot have experienced a recent cardiac event, have atrial fibrillation or other arrhythmias or be at risk for lymphedema.**

MEDICAL PROVIDER INFORMATION

Medical Provider Name: _____

Practice Name: _____

Office Phone: _____ Office Fax: _____

Medical Provider Certification
This patient is:

☐ Not cleared to exercise at this time ☐ Cleared to exercise with no restrictions
☐ Cleared to exercise with the following restrictions. Please list restrictions below:

_____
_____
_____
_____

☐ I have obtained participant authorization to release information to the YMCA and to include the patient's most recent medical records.

Medical Provider Signature _____ **Date** _____

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PARTICIPANT INFORMATION

Participant Name: _____

Address: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Insurance Carrier: _____

Birthdate: _____ Height: _____ Weight: _____Gender: _____

Signature and consent: _____ **Date:** _____

PARTICIPANT MEDICAL INFORMATION

Does the patient have pre-diabetes?* ☐ Yes ☐ No If yes, date diagnosed _____

*For patients with pre-diabetes or diabetes, please include most recent labs with medical records.

HbA1C: _____ Fasting Glucose: _____

2-hour plasma glucose: _____ Oral agent or insulin prescribed: ☐ Yes ☐ No

Does the patient have high blood pressure? ☐ Yes ☐ No If yes, date diagnosed: _____

Is patient 18 years or older? ☐ Yes ☐ No

***Participants cannot have experienced a recent cardiac event, have atrial fibrillation or other arrhythmias or be at risk for lymphedema.**

<u>Eligibility Requirements</u>: Members who currently have diabetes would not be eligible since this program is preventative.

Fax Completed Form to 1-833-706-0238

Both sides of this form must be completed