

# YMCA's Diabetes Prevention Program Referral Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Medicare ID Number (AB only): \_\_\_\_\_ Spanish Speaking Required?: \_\_\_\_\_

## To qualify, participants must:

1. be at least 18 years of age; and
2. be overweight or obese (Body Mass Index  $\geq 25$ ,  $\geq 22$  if Asian); and
3. have prediabetes, as verified by a blood test.

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

#### Body Mass Index

Height: \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds BMI: \_\_\_\_\_ kg/m<sup>2</sup> (Must be  $\geq 25$ ,  $\geq 22$  if Asian)

#### 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).

#### Health Information Release

I \_\_\_\_\_ DID obtain patient authorization to release this information to the YMCA (see reverse [page 2] to complete the Authorization to Release Health Information).

#### Provider Information

Provider Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practice Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



# YMCA's Diabetes Prevention Program Referral Form

## 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 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 front page, except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, 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!  
Please fax the completed form to Judy Ouziel at 917-441-9569.  
Questions? Need more information? Call 212-912-2524.



YMCA Of Greater NY  
5 West 64<sup>th</sup> Street  
New York, NY 10023  
Tel: 212.912.2524 ♦ Fax: 917.441.9569  
Rev. 2/13

