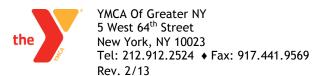
YMCA's Diabetes Prevention Program Referral Form

Patient Name:				
Date of Birth:	Phone:	Email:		
Medicare ID Number (AB only):	Spanish Speaking Required?:	Spanish Speaking Required?:	
	To be co	ompleted by health care provider		
Body Mass Index				
Height: in	ches Weight: pou	unds BMI: kg/m ² (Must be \geq 25, \geq 22 if Asian)		
Pre-Diabetes Inform	nation (check all that apply A	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 A	C % (5.7%	0-6.4%)		
Participation Inforn	nation (check one)			
	to achieve a 7% weight redu	nis patient participate in the YMCA's Diabetes Prevention Progra action through changes in nutrition and physical activity (up to 15		
Health Information	Release			
	atient authorization to release ease Health Information).	e this information to the YMCA (see reverse [page 2] to complete	te the	
Provider Information	n			
Provider Name:				
Provider Signature:		Date:		
Practice Contact:		Phone:		
Practice Name:		Fax:		
Address:		City:State: Zip:		





YMCA's Diabetes Prevention Program Referral Form

AUTHORIZATION TO RELESE 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.



Health

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