YMCA's Diabetes Prevention Referral Form

Participant's Name (Please Print) Date of Birth

Participant's Street Address City State Zip Code

Insurance United Health Care Medicare Claim # (Last 4 Digits) Other

Phone Number Email

Gender Height Weight

Lab Values/Diagnosis

☐ Fasting Plasma Glucose _____ (range 100-125 mg/dl)
☐ 2-hour Plasma Glucose _____ (range 140-199 mg/dl)
☐ A1C _____ (range 5.7-6.4%)

Physician Name

Contact
Caroline Rankin
phone 614 384 2281 fax 614 384 2306
crankin@ymcacolumbus.org

Julie Dodge
Phone 614 384 2304
jdodge@ymcacolumbus.org

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: _____