FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA'S DIABETES PREVENTION PROGRAM
PHYSICIAN REFERRAL FORM

Patient Name: _____

Date of Birth: _____ Phone: _____ Email: _____

To qualify, participants must:

1. Be at least 18 years of age; and
2. Be overweight or obese (Body Mass Index ≥25, ≥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^2 (Must be ≥25, if Asian BMI ≥ 22)

Pre-Diabetes Information (Check all that apply AND enter values)

____ 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 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: _____

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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 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: _____

Please return the completed form to:

Karen Kalkhoff
EBHI Coordinator
9250 N. Green Bay Avenue
Brown Deer, WI 53209
(P) 414-357-2811
(E) kkalkhoff@ymcamke.org

Thank you for your referral!