



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## YMCA's DIABETES PREVENTION PROGRAM REFERRAL FORM

SHASTA FAMILY YMCA

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

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

English speaking? \_\_\_\_\_ Spanish speaking? \_\_\_\_\_ Other? \_\_\_\_\_

To qualify participants must:

- Be at least 18 years of age;
- Have a Body Mass Index of  $\geq 25$ , or  $\geq 22$  (if Asian); and
- Have pre-diabetes as verified by blood test

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

### Body Mass Index

Height: \_\_\_\_\_ in Weight: \_\_\_\_\_ lbs. BMI: \_\_\_\_\_ kg/m (Must be  $\geq 25$ , or  $\geq 22$  if Asian)

Male: \_\_\_\_\_ Female: \_\_\_\_\_

### 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 all that apply)

I \_\_\_\_\_ DO 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).

I \_\_\_\_\_ DID obtain patient authorization to release this information to the YMCA

(please complete second page) OR \_\_\_\_\_ I referred patient to YMCA for follow up.

### AUTHORIZATION TO RELEASE HEALTH INFORMATION.

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

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

Practice Contact: \_\_\_\_\_ Phone: \_\_\_\_\_/Fax: \_\_\_\_\_



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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 Shasta Family 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 YMCA's Diabetes Prevention Program Referral form, except to the extent that the action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. I further understand that my treatment, payment, enrollment in a health plan, and 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!**

**Give Patient completed form to bring to YMCA for enrollment.  
Questions? Please call Pauline Asbill 530.768-2185**