

# Physician Referral Form

I am referring my patient to the following YMCA program(s).

**YMCA Diabetes Prevention Program (for those with pre-diabetes)**

One-year program to help adults reduce their risk of converting to full diabetes by learning about physical activity and nutrition, leading to weight loss and risk reduction.

**Who is eligible?**

Adults with pre-diabetes, BMI  $\geq 25$  kg/m<sup>2</sup> is required; Asian individual(s) BMI  $\geq 23$  kg/m<sup>2</sup>

**Meets blood value / diagnosis qualifications:** A1c must be 5.7% - 6.4%

**Healthy Weight and Your Child**

26-session program helping youth reach a healthy weight and live a healthier lifestyle.

**Who is eligible?**

Children 7-13 years old with a BMI of the 95th percentile or higher

**Both sides of this form must be completed**

**FAX both sides of completed form to:**

**North Carolina Alliance of YMCA - Secure Fax 866-241-4328**

# Physician Referral Form

## MEDICAL PROVIDER INFORMATION

Medical Provider Name \_\_\_\_\_ Practice Name \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_

Medical Provider Certification:

This patient is:

- Not cleared to exercise at this time       Cleared to exercise with no restrictions  
 Cleared to exercise with the following restrictions. Please list restrictions below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- I have obtained participant's authorization to release information to the YMCA and to include the patient's most recent medical records.

Medical Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

---

## PARTICIPANT INFORMATION

Participant Name \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Cellphone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Birthdate \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_

Signature and consent \_\_\_\_\_ Date \_\_\_\_\_

## PARTICIPANT MEDICAL INFORMATION

Does the patient have pre-diabetes\*?  Yes  No If yes, date diagnosed \_\_\_\_\_

\*For patients with pre-diabetes or diabetes, please include most recent labs with medical records.

HbA1C: \_\_\_\_\_ Fasting Glucose \_\_\_\_\_

2-hr plasma glucose \_\_\_\_\_ Oral agent or insulin prescribed?  Yes  No

North Carolina Alliance of YMCA – Secure Fax 866-241-4328