WellCare

the Y YMCA

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 ≥ 25 kg/m2 is required; Asian individual(s) BMI ≥ 23 kg/m2

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?
7-13-year-olds with a BMI of the 95th percentile or higher

Both sides of this form must be completed

FAX both sides of completed form to:

HIPPA Secure Fax 844-621-2799

Questions: info@ncymcas.org

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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 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

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