YMCA's Diabetes Prevention Program Referral Form

Patient Name: _____

Date of Birth: _____ Phone: _____ Email: _____

Insurance: _____ Spanish Speaking Required?: _____Sex: _____

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, ≥ 22 if Asian)

Pre-Diabetes Information (*check all that apply AND enter value***):**

____ Fasting plasma glucose (FPG) _____ mg/dL (110-125 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 reverse [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: _____

YMCA Of Greater NY
5 West 63rd Street
New York, NY 10023
Tel: 212.630.9619 ♦ Fax: 646.349.1232
Rev. 2/18

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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: _____

Thank you for your referral
Please fax the completed form to Jordan Correa at 646-349-1232
Questions? Need more information? Call 212-630-9619

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