

YMCA'S DIABETES PREVENTION PROGRAM REFERRAL FORM

SECTION 1: PARTICIPANT DETAILS

First name* _____
Middle name _____
Last name* _____
Gender* _____
Date of birth* _____

Race

- American Indian or Alaska Native
 Asian White
 Native Hawaiian or Other Pacific Islander
 Black or African American
 White

SECTION 2: PARTICIPANT CONTACT INFORMATION

Email address _____
Street 1* _____
City* _____
State* _____
Postal code* _____
Home phone _____
Mobile phone _____

SECTION 3: PARTICIPANT QUALIFICATION CRITERIA

Height (ft)^{**} _____ Height (in)^{**} _____ Weight (lbs)^{**} _____
Meets Blood Value/Diagnosis Qualification: **
 A1c: _____ (must be 5.7%-6.4%)
 Fasting Plasma Glucose: _____ (must be 100-125 mg/dL)
 2-hour (75 gm glucola) Plasma Glucose: _____ (must be 140-199 mg/dL)
 Prediabetes determined by clinical diagnosis of Gestational Diabetes (GDM) during previous pregnant

**An individual already diagnosed with type 1 or type 2 diabetes does not qualify for this program.

SECTION 4: PROVIDER CONTACT INFORMATION (Include name of practice or office if applicable)

Provider Name _____
Name of Practice _____
Street 1 _____
City _____ State _____ Postal Code _____
Phone _____ Fax _____
Email address _____

SECTION 5: AUTHORIZATION TO RELEASE INFORMATION

(To be read and signed by the patient's provider.) I (the provider) would like to refer this participant to the YMCA's Diabetes Prevention Program. I have obtained participant authorization to release information to the YMCA of Upper Palmetto YMCA, and I agree to inform the Upper Palmetto YMCA if this participant changes or revokes this authorization.

Provider Name (print) _____
Provider Signature _____ Date _____