FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Healthy Weight and Your Child REFERRAL FORM

YMCA of Greater Houston

Patient Name: _____

Date of Birth: _____ Phone: _____ E-mail:_____

English speaking? _____ Spanish speaking? _____ Other? _____

To qualify participants must:

- Be between 7-13 years of age
- Be in the 95th percentile of Body Mass Index (BMI) for their gender and age, have cognitive ability to participate, be able to walk without assistance.

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

Body Mass Index

Height: _____ in Weight _____ lbs. BMI: _____ kg/m

Body Mass Index Percentile (must be **above** 95%): _____

Male: _____ Female: _____

Special health considerations such as sleep apnea, diabetes, or heart condition (please specify):_____
_____
_____

Participation Information (check one)

I _____ DO _____ DO NOT recommend that this patient participate in Healthy Weight and Your Child, a one year evidence-based weight management program where he/she will engage in physical activity and nutrition education.

I _____ DID obtain patient authorization to release this information to the YMCA (please complete form below).

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 YMCA of Greater Houston for the purpose of referring my child to Healthy Weight and Your Child. I have the right to revoke this authorization at any time by writing to the health care provider named on the Healthy Weight and Your Child 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 child's 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 of Parent or Legal Guardian: _____

Date: _____

Thank you for your referral!
Please fax the completed form to
1-888-978-7606