FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA's DIABETES PREVENTION PROGRAM REFERRAL FORM
YMCA of Greater Houston

Patient Name: _____

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

Check one: English speaking? ____ Spanish speaking? _____ Other? _____

To qualify participants must:

- **Be at least 18 years of age;**
- **Have a Body Mass Index of ≥25, or ≥23 (if Asian); and**
- **Have pre-diabetes as verified by blood test**

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

Body Mass Index (complete all)

Height: _____ in Weight: _____ lbs BMI: _____ kg/m (BMI must be ≥25 **OR** ≥ 23 if Asian)

Male: _____ Female: _____

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

____ Hemoglobin A1C _____ % (5.7%-6.4%) **or**

____ Fasting plasma glucose (FPG) _____ mg/dL (100-125 mg/dL) **or**

____ 2- hour plasma glucose (OGTT) _____ mg/dL (140-199 mg/dL) **or**

____ Gestational Diabetes (GDM) during previous pregnancy

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).

I ____ DID obtain patient authorization to release this information to the YMCA

Provider Name: _____ Practice Name: _____

Provider Signature: _____ Date: _____

Practice Contact: _____ Phone: _____ Fax: _____

Please complete second page.

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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 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 YMCA's Diabetes Prevention Program 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 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's name (print): _____

Signature: _____

Date: _____

Thank you for your referral!
Please do not email this form.
Fax to 1-888-978-7606 (HIPAA secure electronic fax line)
Questions? Please call 713-758-9152 or email
diabetes.prevention@ymcahouston.org