DIABETES PREVENTION PROGRAM REFERRAL FORM

PATIENT INFORMATION:

Patient Name:			Date:
Date of Birth:	Home Phone:	Cell Phone:	
Address:			
City, State, Zip:			
E-Mail			

Patients must be 18 years and older and have a BMI of 25 or greater.

Select qualifying LAB VALUES *or* RISK FACTORS below.

Lab Values	Risk Factors (two or more)
☐ A1C value = _____% (must be 5.7%-6.4%)	☐ Elevated Blood Pressure
	☐ Elevated Cholesterol
☐ Fasting glucose = _____mg/dL (must be 100-125mg/dL)	☐ Family Hx of type 2 Diabetes
	☐ Exercises 2 or less x per week
☐ Non-fasting glucose = _____mg/dL (must be 140-199 mg/dL)	☐ History of gestational Diabetes
	☐ Aged 45 or older
Height _____ Weight_____ BMI_____	

PROVIDER INFORMATION:

Provider Name:_____ Practice Name: _____

Signature:_____ Phone:_____ Fax:_____

PATIENT AUTHRORIZATION:

Patient Signature: _____ Date: _____

By signing this form, I authorize my physician to disclose my screening results to the YMCA for the purpose of determining my eligibility for the YMCA's Healthy Living Program and conduction other activities as permitted by law. I understand that I am not obligated to participate in this screening program and that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation.

Please fax completed form to the whatcom Family YMCA (360) 734-8406

Please keep a copy for your records. If you have any questions or want more information:

Contact Tara Marshall at 302-255-0643 or Tmarshall@whatcomymca.org