YMCA's Diabetes Prevention Program

Physician Referral Form

Please complete the following form for qualified patients:

Patient Name: _____

Date of Birth: _____

Phone: _____

**** To qualify, participants must:**

1. Be at least 18 years of age; and

2. Be overweight or obese (Body Mass Index of ≥25, ≥22 if Asian); and

3. Have prediabetes, as verified by a blood test

Body Mass Index:

Height: _____inches Weight: _____pounds BMI:_____kg/m2 (must be ≥25, ≥22 if Asian)

Prediabetes Information (Check all that apply AND enter value):

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

_____2-hour plasma glucose (OGTT) _____ mg/dL (140-199 mg/dL) or

_____Hemoglobin A1c _____ % (5.7% - 6.4%)

Please complete back side of form

Health Information Release: I 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).

Provider Information:

Provider Name: _____

Date: _____

Practice Contact: _____

Phone: _____

Practice Name: _____

Fax: _____

Address: _____

City: _____State: _____ Zip: _____

Please Fax to:

Rhoda Kasparek
Director of Healthy Living
Riverbrook Regional YMCA
203-286-1633