FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

DIABETES PREVENTION PROGRAM

PROGRAM REFERRAL

PATIENT INFORMATION

Patient Name:	Date of Birth:
Phone:	Gender:
E-Mail:	

PARTICIPANT ELIGIBILITY

- ☐ **18 years or older**
- ☐ **Diagnosed with pre-diabetes or at risk for developing diabetes**

Please check the appropriate qualifiers

- ☐ **A1C 5.7% - 6.4%**
- ☐ **Fasting Plasma Glucose 100 – 125 mg/dl**
- ☐ **2-Hour Plasma Glucose (75 gm glucose) 140 – 199 mg/dl**
- ☐ **Clinical Diagnosis of Gestational Diabetes (GDM) During Pregnancy**

PROVIDER INFORMATION

Provider Name:	Phone:
Signature:	Fax:

PATIENT AUTHORIZATION

Parent/Guardian Signature:	Date:

By signing this form, I authorize my physician to disclose my screening results to the YMCA of The Roses 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.

Return completed form for York County Clients to Kyle Almoney, kalmoney@rosesymca.org or 717-854-1857 x248

Return completed form for Lancaster County Clients to Jessica Rodriguez, jrodriguez@rosesymca.org or 717-464-4000 x1220

Fax Number: 717-854-1857