YMCA MEDICAL MEMBERSHIP REFERRAL
YMCA of the Triangle

PARTICIPANT DETAILS

Name _____

DOB_____ Gender (circle one) M F Insurance Carrier_____

Telephone Number_____Email _____

PARTICIPANT PROGRAM WITH RELEVENT REFERRAL INFORMATION

□ LIVE**STRONG** at the YMCA: 12-week, 24-session cancer survivor program focused on physical activity.
Brief history_____

_____

□ Diabetes Prevention Program: 12-month program for pre-diabetics or at high risk of developing DM with risk factors. List any value of prediabetes "or risk factors". _____

_____

□ Blood Pressure Self-Monitoring: 4-month program for patients with high blood pressure to monitor, track, increase physical activity, and heart healthy eating. Patients eligibility: no recent cardiac event, not have atrial fibrillation or other arrhythmias, not be at risk for lymphedema.

_____

□ Weight Loss Program: 12-week, group-based nutrition and exercise tracking and goal setting program.

_____

□ Healthy Weight and Your Child: 15-week, family-based, weight management program for children ages 7-13 with (95% BMI or greater). Height_____Weight_____BMI _____

□ Moving for Better Balance: 12-week, 24-session falls prevention program.
Brief history_____

REQUIRED MEDICAL CLEARANCE AND AUTHORIZATION TO RELEASE INFORMATION

My patient above is: □ Not cleared to exercise at this time □ Cleared to exercise with no restrictions
□ Cleared to exercise with the following restrictions_____

I (the provider) have obtained participant authorization to release information to the YMCA of the Triangle.

Provider Practice (please print)_____

Provider Signature _____Date_____

Patient Signature or Oral Consent_____Date _____

For questions and to return the forms, contact:

Amy Ward, 919-257-3088, amy.ward@ymcatriangle.org, HIPAA compliant fax at 1-844-621-2799

Visit https://www.ymcatriangle.org/medical-memberships to learn more about YMCA Medical Memberships.