Y HEALTH MEMBERSHIP REFERRAL
YMCA of the Triangle

PARTICIPANT DETAILS

Name_____Insurance Company_____

DOB_____Gender (circle one): ☐ M ☐ F

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_____

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☐ 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 eligiblity: no recent cardiac event, not have atrial fibrillation or other arrhythmias, not be at risk for lymphedema. _____

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

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☐ Healthy Weight and Your Child: 15-week, family-based, weight management program for children (95% BMI).
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 _____

Provider Name (please print)_____NPI# _____

Patient Signature or Oral Consent_____Date _____

For questions and to return the forms, contact our Community Health Team:
919-582-9396; Medical.Membership@ymcatriangle.org; HIPAA compliant fax at 1-844-621-2799; Direct Messaging: triangle@direct.mywelld.com;
Visit https://www.ymcatriangle.org/membership/y-health-memberships to learn more.