



PARTICIPANT DETAILS

Name _____ Insurance Company _____

DOB _____ Gender (circle one): M F

Telephone Number _____ Email _____

PARTICIPANT PROGRAM WITH RELEVANT REFERRAL INFORMATION

- ☐ **LIVESTRONG** 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 (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: TriangleYMCA@direct.mywellid.com;

Visit <https://www.ymcatriangle.org/membership/y-health-memberships> to learn more.