YMCA of Metropolitan Washington
1112 16th Street NW, Suite 240
Washington, DC 20026
health@ymcadc.org
Secure Fax: 833-264-1179

HEALTH CARE PROVIDER REFERRAL FORM

Do not use for medical emergencies.

Referring Provider: _____ **Hospital/Clinic:**_____

Email:_____ **Phone Number:**_____

Patient to be referred to (please check all that apply):

[ ] Diabetes Prevention Program
- [ ] Adult 18+
- [ ] BMI ≥ 25; Asian individuals ≥ 23

AND, one of the following:
- [ ] A1c between 5.7%-6.4% OR
- [ ] Fasting Blood Glucose 100-125 md/dL OR
- [ ] Diagnosis of Gestational Diabetes

[ ] Blood Pressure Self-Monitoring
- [ ] Patient has been diagnosed with high blood pressure

[ ] The Community Table
- [ ] Patient demonstrates interest in nutritional knowledge and cooking skills

[ ] Dietetic Counseling
- [ ] Patient demonstrates interest or need in one-on-one sessions with a registered dietitian. *Please complete patient information:*

A1c: _____ Blood Pressure: _____

BMI: _____ Cholesterol: _____

Additional notes: _____

Patient Information: must be completed for all programs.

Patient Name	
Patient DOB	
Phone Number (please provide two)	
Best time to contact?	
Is it OK to leave a leave a message?	[ ] YES [ ] NO
Is it OK to text?	[ ] YES [ ] NO

This program is funded wholly, or in part, by the Government of the District of Columbia Department of Health, Community Health Administration.

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AUTHORIZATION TO RELEASE INFORMATION

This section is to be read and signed by the patient and his/her provider.

I agree and request that the health information on the front of this form is true and is to be released to the YMCA for the purpose of referring me to _____ *(program name).* I have the right to revoke this authorization at any time by writing to my health care provider named on the front page, except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, and/or enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

Patient Name (please print) _____

Patient Signature _____**Date** _____

I (the provider) have obtained patient authorization to release information to the YMCA of Metropolitan Washington.

Provider Name (please print) _____

Provider Signature _____**Date** _____

Please fax completed forms to secure fax #: 833-264-1179

Questions? Email health@ymcadc.org

Thank you for your referral. The YMCA Care Coordinator will reach out within 72 hours.

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