the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF METROPOLITAN WASHINGTON

PRESCRIBE THE Y

REFER YOUR PATIENTS INTO YMCA HEALTH PROGRAMS

The YMCA of Metropolitan Washington offers virtual health promotion and chronic disease prevention programs across the Metropolitan Washington area for YMCA members and community members.
The chart to the right describes targeted conditions and inclusion criteria. Program descriptions are below.

Email **health@ymcadc.org** for more information.

Program	Condition Targeted	Inclusion Criteria
Diabetes Prevention Program	Type 2 Diabetes prevention	• Adults 18+ • BMI ≥ 25, Asian individuals ≥ 23 • Blood values of either: ◦ A1c between 5.7%-6.4% OR ◦ Fasting glucose 100-125 mg/dL OR ◦ Diagnosis of gestational diabetes
Blood Pressure Self-Monitoring	Heart disease prevention and management	• Adults 18+ • Diagnosis of high blood pressure • Must be free of cardiac events, arrhythmias or lymphedema
Dietetic Counseling	Prevention and management of common chronic diseases and conditions such as obesity, heart disease, diabetes, cancer, kidney disease, and digestive disorders.	• Patient demonstrates desire or need for one-on-one sessions with a registered dietitian
Simple Cooking With Heart	Nutritional knowledge & cooking skills	• Families interested in nutritional knowledge and cooking skills

Referral forms can be sent via:
Secure Fax: 833-264-1179 | **Secure HISP Email:** ymcadchealth@direct.mywelld.com

PROGRAM DESCRIPTIONS

Diabetes Prevention Program (DPP):

DPP is a one-year program of 25 small group supportive classroom sessions. Participants learn about healthy eating and increasing physical activity to reduce risk of diabetes. We accept insurance payment for this program. Cost: $429
The goal is that each participant reduces body weight by 5-7% and increases physical activity to 150 minutes/week.

Blood Pressure Self-Monitoring Program (BPSM):

BPSM is a 4-month program where participants will receive: coaching to track blood pressure at home, two 10-minute one-on-one check-ins per month, and monthly nutrition seminars. Participants will receive their own blood pressure monitor. Cost: $210. **Available in Spanish.**
The goal is that participants track, monitor and reduce their blood pressure.

Dietetic Counseling:

Meet one-on-one with our registered dietitian for medical nutrition therapy, to include an assessment and personalized nutrition care plan, with follow-up sessions in support of behavioral and lifestyle changes leading to improved health outcomes. Cost: $110

Simple Cooking With Heart:

Simple Cooking With Heart is a 4-week SNAP-Ed nutrition and culinary education program. Participants will receive bags of groceries each week of participating. Cost: $280. **Available in Spanish.**
The goal is that participants increase nutritional knowledge and cooking skills.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
This program is funded wholly, or in part, by the Government of the District of Columbia Department of Health, Community Health Administration

Programs are available to all. Scholarships available upon request. Email health@ymcadc.org or call 202-329-7358.

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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 (Available in Spanish)**
  - ☐ Patient has been diagnosed with high blood pressure
- ☐ **Simple Cooking With Heart (Available in Spanish)**
  - ☐ Patient demonstrates interest in nutritional knowledge and cooking
- ☐ Is [ ] **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
Preferred Language	☐ English ☐ Spanish

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YMCA of Metropolitan Washington
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ymcadchealth@direct.mywelld.com
Secure Fax: 833-264-1179

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** _____

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

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