



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 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 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.