DIABETES PREVENTION PROGRAM

REFERRAL AND RELEASE FORM

Please fax completed form to 1-844-671-9053.
For questions, contact the Center for Health Innovation at 615-259-9622, ext. 70198.

****To be completed by health care provider****

Patient name: _____

Patient street address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ Phone: _____ Email: _____

TO QUALIFY, PARTICIPANTS MUST:

1. Be at least 18 years of age; **AND**
2. Be overweight or obese (Body Mass Index ≥ 25, ≥ 22 if Asian); **AND**
3. Have prediabetes, as verified by blood test, OR, determined by clinical diagnosis of gestational diabetes.

BODY MASS INDEX

Height: _____ inches Weight: _____ pounds BMI: _____ kg/m^2
(Must be ≥ 25, ≥ 22 if Asian)

PREDIABETES INFORMATION (Check all that apply AND enter value):

_____ Fasting plasma glucose (FPG) _____ mg/dL (100-125 mg/dL) or
_____ 2-hour plasma glucose (OGTT) _____ mg/dL (140-199 mg/dL) or
_____ Hemoglobin A1C _____ % (5.7%–6.4%)
_____ Clinical diagnosis of gestational diabetes during previous pregnancy

PROVIDER INFORMATION

Provider name: _____

Provider signature: _____ Date: _____

Practice name: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

****To be completed by patient****

By signing my name below, I agree and request that the health information on this form be released to the YMCA of Middle Tennessee for the purpose of referring me to the YMCA's Diabetes Prevention Program for care.

I understand that my participation in the YMCA's Diabetes Prevention Program and the release of my information are voluntary. I understand that if I do not consent to this release of my information, the YMCA Diabetes Prevention Program will not receive my health information in order to provide care to me.

Patient name: _____

Patient signature: _____ Date: _____