



YMCA REFERRAL FOR CHRONIC CONDITION PREVENTION & MANAGEMENT

(Department/Provider) _____ requesting an appointment by YMCA

Patient to be referred to:

YMCA’s Diabetes Prevention Program

Pt has met all eligibility criteria

- A1c between 5.7-6.4 *OR*
- Fasting Blood Glucose 100-125
- BMI >25; for Asians - BMI >22

ACT! - Youth Obesity Prevention Program

Pt has met both eligibility criteria

- BMI >85th percentile; Enter BMI: _____
- Age 8-14yrs; Age: _____

Lose to Win – Weight Management

Pt has met all eligibility criteria

- BMI >25

Pedaling for Parkinson’s – Parkinson’s Management

Pt has met eligibility criteria

- Patient has been diagnosed with idiopathic Parkinson’s disease

Blood Pressure Self-Monitoring

- Patient has been diagnosed with high blood pressure

General Health & Wellness or Fitness Support (including interest in YMCA Membership)

Enhance®Fitness – Rehabilitation & Arthritis Management

Mental Health Counseling (All Ages)

- Individual
- Family

LIVESTRONG® at the YMCA – Cancer Survivorship

Patient Information:

Patient Name and DOB:	DOB: ____/____/____
Parent/Guardian Name (if patient is a minor):	
Phone Number:	
Email Address:	
Primary Language:	
Best time to call (between 08:00 and 17:00):	
OK to leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
OK to text?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient consents to YMCA follow-up/outreach:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Comments:

SEND REFERRAL TO YMCA of Greater Seattle SECURE FAX: **844.836.8957**

Questions? Call 206.432.8904 or email ChronicDiseasePrevention@seattleyymca.org