



Diabetes Prevention Program YMCA OF SAN FRANCISCO

PROVIDER REFERRAL FORM

SECTION 1: PARTICIPANT DETAILS

*First Name _____ Middle Int. _____

*Last Name _____

*DOB _____ *Gender Female Male

*Spanish Speaker? Yes No Bilingual

*RACE/ETHNICITY

- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- Hispanic/Latino of any race
- White

SECTION 2: PARTICIPANT QUALIFICATION CRITERIA

*Height _____ *Weight (lbs) _____ For program participation BMI \geq 25. Asian individual(s) BMI \geq 22.

*Blood Values and Diagnosis. Please check all that apply and provide appropriate values.

- A1c: _____ (must be 5.7%-6.4%)
- Fasting Plasma Glucose: _____ (must be 100-125 mg/dL)
- 2-hour (75 gm glucola) Plasma Glucose: _____ (must be 140-199 mg/dL)
- Gestational Diabetes (GDM) during current or previous pregnancy

An individual already diagnosed with type 1 or type 2 diabetes does not qualify for this program.

SECTION 3: FAMILY & HEALTH HISTORY

Please select the appropriate answer for the following questions.

- | | | |
|--|-----|----|
| *Is the candidate a woman who has had a baby weighing more than 9 pounds at birth? | Yes | No |
| *Does the candidate have a parent with diabetes? | Yes | No |
| *Does the candidate have a brother or sister with diabetes? | Yes | No |
| *Does the candidate have a BMI of 25 or greater (22 or greater for Asian)? | Yes | No |
| *Does the candidate perform little to no physical activity in a typical day? | Yes | No |
| *Is the candidate age 65 years or older? | Yes | No |

SECTION 4: PARTICIPANT CONTACT INFORMATION

*Street 1 _____ Unit/Apt. # _____

*City _____ *State _____ *Postal code _____

*Primary phone _____ Email (if available) _____

SECTION 5: PROVIDER CONTACT INFORMATION (Include name of practice or office if applicable)

*Provider Name _____

*Name of Practice _____

*Street 1 _____

*City _____ *State _____ *Postal Code _____

*Phone _____ *Fax _____

*Email address _____

*I am a:

- Doctor/Physician
- Nurse Practitioner or Physician Assistant
- Nurse
- Diabetes Educator
- Dietician/Nutritionist
- Dentist
- Pharmacist

Research by the National Institutes of Health has proven that programs like the YMCA's Diabetes Prevention Program can reduce the number of cases of type 2 diabetes by 58%, and 71% in adults over age 60.

**Required information to complete enrollment*



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AUTHORIZATION TO RELEASE INFORMATION

This section is to be read and signed by the participant's provider.

PROGRAM ELEMENTS (Key information to share with your patients)

- Program is one year long - attend 25 one-hour sessions over the course of one year
- Small-group (8-15 people) supportive environment, led by a trained Lifestyle Coach
- Learn strategies for healthy eating, increasing physical activity and managing stress to achieve two program goals:
1) 7% total body weight loss and 2) 150 minutes of moderate physical activity per week
- Receive 4 months of free YMCA membership with your participation and attendance in the program

I (the provider) would like to refer this participant to the YMCA's Diabetes Prevention Program. I have obtained participant authorization to release information to the YMCA of San Francisco, and I agree to inform the YMCA of San Francisco if this participant changes or revokes this authorization.

***Provider Name (please print)** _____

***Provider Signature** _____ ***Date** _____

Please return completed forms to:

Emily Turpin
Health Initiatives Program Director
YMCA of San Francisco
50 California Street, Suite 650
San Francisco, CA 94111
Phone: (415) 281-6702
Fax: (415) 398-9622
Email: eturpin@ymcasf.org

Thank you for your referral!