Diabetes Prevention Program
YMCA OF SAN FRANCISCO

PROVIDER REFERRAL FORM

**Required information to complete enrollment*

SECTION 1: PARTICIPANT DETAILS

*Name (First, Last) _____

*DOB _____ *Gender ☐ Female ☐ Male

Patient ID Number (optional) _____

*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
☐ Other _____

SECTION 2: PARTICIPANT CONTACT INFORMATION

*Street 1 _____ Unit/Apt. # _____

*City _____ *State _____ *Postal code _____

*Primary phone _____ Email (if available) _____

SECTION 3: PARTICIPANT QUALIFICATION CRITERIA

*Height _____ *Weight (lbs.) _____ **Required BMI ≥ 25. Asian individual(s) BMI ≥ 22.**

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

☐ HbgA1c: _____ (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 4: 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
☐ Other _____

SECTION 5: AUTHORIZATION TO RELEASE INFORMATION (To be read and signed by the patient's provider.)

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 (print)** _____

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

Return completed forms to:
Emily Turpin, Health Initiatives Program Director
YMCA of San Francisco – 50 California Street, Suite 650, San Francisco, CA 94111
Ph: 415-281-6702 **Fax: 415-398-9622** E: Eturpin@ymcasf.org