HELPING YOURSELF TO HEALTH
SMALL STEPS ARE THE START.

Provider Referral to YMCA's Diabetes Prevention Program

Send to: FAX 802.652.8191 email: ymcadpp@gbymca.org

Patient Information	
First Name:	Address:
Last Name:	
Birth Date:	City:
Gender:	State / ZIP code:
Email:	Phone number:

By providing your information above, you authorize your health care practitioner to provide this information to the YMCA's Diabetes Prevention Program provider, who will use this information to communicate with you regarding enrollment in the program.

Practitioner Information	
Provider:	Address:
Practice contact:	City:
Phone:	State:
Fax:	ZIP code:

Screening Information			
Body-Mass Index (BMI)			eligibility ≥25, ≥22 if Asian
Blood test (check one)	Eligible range	Test result	Date of test
___ Hemoglobin A1c	5.7–6.4%		
___ Fasting Plasma Glucose	100–125 mg/dL		
___ 2-hour plasma glucose (75 gm OGTT)	140–199 mg/dL		
___ Gestational Diabetes (in a prior pregnancy)			

By signing this form, I authorize my practitioner to disclose my diabetes screening results to the YMCA's Diabetes Prevention Program for the sole purpose of determining my eligibility for the diabetes prevention program.

I understand that I am not obligated to participate and that this authorization is voluntary.

I understand that I may revoke this authorization by notifying my provider in writing. Any revocation will not have an effect on actions taken before my provider received said revocation.

Patient Signature   Date

To find resources for your patients, visit:
MYHEALTHYVT.ORG