YOU CAN TAKE CONTROL

with a program for adults at risk for diabetes or with a diagnosis of pre-diabetes.

DIABETES PREVENTION PROGRAM

YMCA of Greater New York & Mount Sinai Diabetes Center

Move. Learn. Inspire.

Mount Sinai's **Viva Fitness** will have you moving to the music and the **YMCA Diabetes Prevention Program (YDPP)*** health coaches will help you meet your health goals, all in a comfortable and fun group setting. The program is 16 weeks, with two one-hour sessions per week. Sessions take place at the Mount Sinai Diabetes Center.

GET STARTED TODAY:

1. Call 212.912.2524 to register* (*If you are a Mount Sinai employee with United Health Care, call 1-800-237-4942)

2. Have your health care provider fill out the form ON BACK OF THIS PAGE (page 2)

*The YDPP is based on research funded by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) which showed that by eating healthier, increasing physical activity and losing a small amount of weight, a person with pre-diabetes can prevent or delay the onset of type 2 diabetes by 58%

YMCA Of Greater NY
5 West 63rd Street
New York, NY 10023
Tel: 212.912.2524
Fax: 917.441.9569

Viva Fitness is supported by Mount Sinai Auxiliary Board and BeWell Mount Sinai

****TO BE COMPLETED BY HEALTH CARE PROVIDER****

Patient Name _____ DOB_____ Phone _____Email _____
☐Please check if patient is Spanish-speaking only

My patient has (select one box):
☐Pre-diabetes
☐No pre-diabetes but does have diabetes risk factors (indicate any risk factors that may apply) ☐overweight/ obesity ☐family history of diabetes ☐history of gestational diabetes

Patient information (fill in any available values)
Height _____ Weight _____ BMI ____
Hemoglobin A1C (5.7%-6.4%) _____ Fasting plasma glucose _____ 2-hour plasma glucose _____

Please respond to 3 questions below. 1 and 2 must be answered for participation.
1. I ☐Do ☐Do Not recommend that this patient participate in the YMCA-Mount Sinai Diabetes Prevention Program

2. This patient ☐Is ☐Is Not capable of mild to moderate exercise

3. I ☐Did obtain patient authorization to release this information to the YMCA (see below) to complete the Authorization.

Provider Signature _____ _____ Date_____

Provider Printed Name _____ Phone _____

Practice Name_____

Address _____ City _____State _____ Zip _____

TO BE COMPLETED BY PATIENT

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I agree and request that the health information on the front of this form be released to the YMCA for the purpose of referring me to the YMCA's Diabetes Prevention Program. I have the right to revoke this authorization at any time by writing to the health care provider named on the front page, except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

Patient name (print): _____

Signature: _____ Date: _____

PLEASE FAX THIS FORM TO JUDY OUZIEL AT 917-441-9569
Questions? Need more information? Call 212-912-2524

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