CHRONIC DISEASE PROGRAM
WILKES-BARRE FAMILY/ GREATER SCRANTON YMCAs

PROVIDER REFERRAL FORM

***** *Required information for program enrollment*

SECTION 1: PARTICIPANT DETAILS

*Name _____ *Date of Birth _____ Gender □ Female □ Male

SECTION 2: PARTICIPANT CONTACT INFORMATION

*Street _____ *City _____

*State _____ *Primary Phone _____

SECTION 3: EVIDENCE-BASED HEALTH INTERVENTIONS

□ YMCA Diabetes Prevention Program (diabetes prevention)

□ LIVESTRONG at the YMCA (cancer survivorship)

□ EnhanceFitness (arthritis management)

SECTION 4: PROVIDER CONTACT INFORMATION

Referring Provider Name _____ Street _____

City _____ State_____ Phone _____

SECTION 5: AUTHORIZATION TO RELEASE INFORMATION

I (the provider) would like to refer this participant to the selected YMCA programs. I have obtained participant authorization to release information to the Wilkes-Barre Family/Greater Scranton YMCAs.

*Provider Name (print) _____

*Provider Signature _____ *Date _____

Please fax completed forms to:
Shadia Lahlou, Senior Director of Chronic Disease Prevention
(WBY Fax) 570 270 2992 | (GSY Fax) 570 340 0432
(P) 570 970 5052