



YMCA of Greater Cleveland
Activate Ohio – Diabetes Self-Management Education Program
Participant Referral/Data Form

All information must be completed at the time of program registration

This section to be completed by program participant:

Participant Name: _____

Please Circle Your Answer for Each of the Following:

Ethnicity: African American Hispanic/Latino Caucasian Appalachian Other

- | | |
|--|-----------|
| 1. Previously diagnosed with Type 1 Diabetes: | Yes or No |
| 2. Previously diagnosed with Type 2 Diabetes | Yes or No |
| 3. Previously diagnosed with Pre-Diabetes* | Yes or No |
| 4. Previously diagnosed with Gestational Diabetes | Yes or No |
| 5. Previously diagnosed with polycystic ovarian syndrome and/or acanthosis nigricans | Yes or No |
| 6. History of vascular disease | Yes or No |
| 7. Family History of diabetes | Yes or No |
| 8. Does Participant Utilize a Medical Clinic: | Yes or No |
| 9. Does the Participant have a Primary Care Physician: | Yes or No |
| 10. Does the Participant have an Eye Doctor: | Yes or No |
| 11. Does the Participant have a Foot Doctor: | Yes or No |
| 12. Does the Participant have a Dentist: | Yes or No |
| 13. Does the Participant have a Registered Dietitian: | Yes or No |

Insurance: Circle One: Medicare/Medicaid Private Uninsured

CONSENT TO RELEASE INFORMATION:

I hereby authorize my Clinic/Provider to give/receive information concerning my health to the YMCA of Greater Cleveland for the purpose of participating in the Activate Ohio Diabetes Education Program.

Patient Signature _____ Date _____

CONTINUED ON BACK

This section to be completed by referring Doctor or Medical Facility:

Participant Name: _____

Name of Medical Facility: _____

Phone # _____ Date: _____

Referring Doctor: _____

Hemoglobin A1C Level: _____ Date: _____

Blood Pressure: _____ Date: _____

Cholesterol: _____ Date: _____

Participant Data:

Age: _____

Weight: _____

Height: _____

Body Mass Index (BMI): _____

Random Blood Sugar Level: _____

Physical Activity Readiness Clearance

Based upon a current review of the health status of _____, I recommend:

_____ No Physical Activity

_____ Only a medically supervised exercise program until further medical clearance

_____ No use of Steam, Sauna, and Whirlpool facilities

_____ Progressive physical activity

_____ with avoidance of: _____

_____ with inclusion of: _____

_____ Unrestricted physical activity-start slowly and build up gradually

Doctors Signature

Date