Livestrong at the YMCA
Program Referral

PATIENT INFORMATION:

Patient Name:	Date of Birth:	Date:
Home Phone:	Cell Phone:	
Address:		
City, State, Zip:		
E-Mail:		

Program Qualifications (please check):

Patient must have all qualifications below to participate in the program.

- ○ Must be 18 years of age or older
- ○ Has a diagnosis of, being treated for, or is a cancer survivor
- ○ Cleared to participate in Physical Activity
  - ➢ Physical Activity Restrictions:

NOTES:

PROVIDER INFORMATION:

Provider Name:_____Practice Name: _____

Signature:_____Phone: _____ Fax:_____

PATIENT AUTHRORIZATION:

Guardian Signature: _____ Date: _____

By signing this form, I authorize my physician to disclose my screening results to the YMCA for the purpose of determining my eligibility for the YMCA's Healthy Living Program and conduction other activities as permitted by law. I understand that I am not obligated to participate in this screening program and that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation.

Please fax completed form to the Healthy Living Department 302-397-2515

Please keep a copy for your records. If you have any questions or want more information:

Contact the Healthy Living Department at 302-571-6998 or tjefferson@ymcade.org.