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 meet all qualification below to participate in the program.

o Must be 18 years of age or older

o Has a diagnosis of, being treated for, or is a cancer survivor

o Cleared to participate in physical activity (please check):

_____Not cleared to exercise at this time
_____Cleared to exercise with no restrictions
_____Cleared to exercise, but must wear a lymphedema sleeve
_____Cleared to exercise with the addition restrictions and/or recommendations

YMCA Branch Location (please circle):

Brandywine Central Western Bear-Glasgow Middletown Dover Sussex

PROVIDER INFORMATION:

Provider Name: _____ Practice Name: _____

Signature: _____ Phone: _____ Fax: _____

PATIENT AUTHRORIZATION:

Patient 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.

E-mail completed form to healthyliving@ymcade.org

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

Contact the Healthy Living Department at 302-572-9622 or healthyliving@ymcade.org