



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

PROGRAM REFERRAL FORM

Provider Please select program(s) referred to patient.

ARTHRITIS

- Enhance Fitness
Water Areobic Arthritis Program

CANCER SURVIVORS

- LIVESTRONG® at the YMCA

MOVEMENT DISORDERS

- Parkinson's Cycling Program
 Parkinson's Exercise Program

OBESITY

- Healthy Weight and Your Child

GENERAL WELLNESS

- First Step Back
 Get Started
 Personal Training

- Prescribe the Y

Reason for the referral: _____

- Cleared to exercise

- Cleared with following restrictions:

Provider Signature: _____

Patient

First Name: _____ Last Name: _____

Email: _____

Phone: _____

Your Doctor's Name: _____

I agree and request that the information on this form be released to the Hampshire Regional YMCA for the purpose of referring me to a wellness program. I have the right to revoke this authorization at any time by writing to the healthcare provider I have listed on this form, except to the extent that action has already been taken based on this authorization.

Patient Signature: _____ Date: _____

RETURN COMPLETED FORM TO:

Ashley Sabourin, Healthy Living Coordinator
P: 413.584.7086 ext.109 Fax: 413.586.1912
E: Ashley.Sabourin@hrymca.org

