FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA: MOVING FOR BETTER BALANCE
Summerville Family YMCA
Participant Referral Form and Authorization for the Release and Sharing of Medical Information

TO BE COMPLETED BY PATIENT

Name:____

Email:____

Address:____ City/State/Zip:____________________________

Gender: _______________ Date of Birth: ___/___/_____ Race: __________________________________

Phone Numbers: (Primary)____________________________ (Secondary)________________________________

Emergency Contact:_________________________________ Emergency Phone:___________________________

Please answer the following: I could participate in a 1-hour weekly class during these times:

□Mid-Morning (10am) □Mid-Afternoon (1pm) □Evening (5:30pm)

I authorize the physician/physical therapist named herein to share the information contained in this form and any other relevant medical information ("protected health information") about my medical condition with the Summerville Family YMCA as part of my participation in the YMCA: MOVING FOR BETTER BALANCE Falls Prevention Program. I understand that this information may include, but not necessarily limited to falls risk assessments, and other protected health information as may be necessary for my participation in the program. I also understand that the Summerville Family YMCA will provide information to my physician as a result of my participation in the program and I hereby authorize such release of information.

Patient Signature:____ Date: ___/___/___

TO BE COMPLETED BY REFERRING PHYSICIAN

Physician Name:________________________________ Practice Name:________________________________

Office Phone:__________________________________ Office Fax:___________________________________

Has patient fallen within the last 12 months: ____Yes ___No If Yes, how many times? ____

If Yes, did fall require medical treatment? ____

I recommend this patient to participate in YMCA: MOVING FOR BETTER BALANCE and certify that this patient would be physically able to participate in 150 minutes per week of low-impact physical activity.

Physician signature: ____ Date: ___/___/___

Please submit completed form to:
Summerville Family YMCA
140 S. Cedar, Summerville, SC 29483
(P) 843-486-1472 (F) 843-821-3127
AmandaM@summervilleymca.org