Blood Pressure Self-Monitoring Program
Michigan YMCAs

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

HEALTH CARE PROVIDER REFERRAL FORM

SECTION 1: PATIENT DETAILS

Name _____ DOB _____ ☐ Female ☐ Male

Phone _____ Email _____

Zip Code _____

SECTION 2: PATIENT QUALIFICATION CRITERIA

Check Yes or No for each question.	**YES**	**NO**
1. Has patient ever been diagnosed with high blood pressure/hypertension?	☐	☐
2. Is patient currently taking prescription medication to control or manage your high blood pressure?	☐	☐
3. Has patient had a recent cardiac event within the last year?	☐	☐
4. Does patient have atrial fibrillation or other arrhythmias?	☐	☐
5. Is patient at risk for lymphedema?	☐	☐
6. Has patient ever been diagnosed with high cholesterol?	☐	☐

If you answered Yes to questions 1 or 2 <u>AND</u> No to questions 3-5, your patient may qualify for this program to help manage hypertension.

SECTION 3: HEALTH CARE PROVIDER INFORMATION

By signing this form, I have obtained patient authorization to release information to the YMCA.

Provider Name_____

Provider Signature _____ Date _____

Phone _____ Fax _____

Please return completed forms to:

BPSM Program Coordinator
kdelong@muskegonymca.org
P: (855) 278-6836
Secure Fax: (231) 525-2890

Thank you for your referral.