# Blood Pressure Self-Monitoring Program

## Michigan YMCAs

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 AND 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.*