YMCA of CATAWBA VALLEY
PHYSICIAN'S REFERRAL

Patient's Name: _____ Date: _____

Address: _____ Phone: _____

_____ Email: _____

Diagnosis (not required): _____

Patient's Signature: _____ Date: _____

Recommended Program:

- ☐ Beginner Exercise
- ☐ Senior Exercise
- ☐ Diabetes Prevention Program
- ☐ LIVESTRONG at the YMCA
- ☐ Parkinson's Disease Program

Limitations Include: _____

_____

The applicant should not engaged in the following activities (please be specific):

_____

_____

_____

_____

Physician's Name: _____ Date: _____

Physician's Signature: : _____

Address: _____ Phone: _____

Physician's Fax: _____ Email: _____

Please fax to:

YMCA of Catawba Valley

Attn: Lala Kozischek—Corporate Wellness Director

828-324-2249