FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LIVE**STRONG**® at the YMCA **Referral Form**

LIVE**STRONG**® at the YMCA is a 12-week physical activity and well-being program designed to help adult cancer survivors achieve their holistic health goals. The research-based program offers post-treatment (up to five years) patients a safe, supportive environment focused on strengthening the whole person. The course includes two classes per week, each lasting 90 minutes (including rest and reflection time, not consistent physical activity). At the start of the program, your patient will participate in a fitness assessment by YMCA staff including a six-minute walk test, one-repetition max test for upper and lower body, and a balance and flexibility test. By completing the form below, you are not assuming any responsibility for the Y's administration of the exercise program. If you know of any medical or other reasons why the applicant should not participate in LIVE**STRONG**® at the YMCA program, please indicate on this form.

PLEASE PRINT APPLICANT INFORMATION BELOW (to be completed by participant or physician)

First Name: _____ **Last Name:** _____ **DOB**____/____/_____ **Male Female**
(Circle one)

Street Address: _____ **YMCA Branch Preference:** _____
(Include Apt. #)

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email Address:** _____

Type of Cancer Diagnosed: _____ **Date of Diagnosis:**_____

When was your last treatment? _____

Participant Signature: _____

To be completed by physician (please select one)**:**

- ☐ I believe the applicant has completed treatment and will be able to participate and complete the program at this time. I know no reason why the applicant may not participate. (Please list any limitations below*)
- ☐ I believe the applicant has completed treatment and can participate but may have limitations or may miss classes due to (circle one):
  1. Severity of disease 2. Co-morbidities (Please list below*)
- ☐ I believe the applicant should defer this program until completion of therapy.
- ☐ I recommend that the applicant NOT participate in the program.

*The applicant should not engage in the following activities, please be specific (use additional paper if necessary):

_____
_____
_____

Name of Applicant: _____

Physician Name: _____ **Physician Contact #:** _____

Physician Signature: _____ **Date:** _____

Physician Fax: _____ **Physician Email:** _____

Please fax completed referral form to 743.219.1070
Questions: Contact Chelsea Mullins, c.mullins@ymcanwnc.org, at 336.245.7228

YMCA OF NORTHWEST NORTH CAROLINA
www.ymcanwnc.org/livestrongattheymca
A United Way Agency. Our Mission: "Helping people reach their God-given potential in spirit, mind and body."