September, 2020

Community Health Network **Program Referral Form**

Patient Information

Name: Gender: ☐ Male ☐ Female ☐ Other

Address: City/Town: State: Zip:

Best Contact Phone: ( ) - Birth Date: / / Email:

Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify)

Primary Diagnosis Code: Secondary Diagnosis Code:

Health Carrier Plan: ☐ BCBSRI ☐ United Healthcare ☐ Neighborhood Health Plan ☐ Tufts ☐ None ☐ Other: ____________

Health Coverage Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Uninsured

Insurance Information

Insured's Name:

Insured's Address:

Relationship to Patient being referred:

Insurance ID Number:

Gender: ☐ Male ☐ Female ☐ Other Birth Date: / /

Health Concerns

☐ Pain
☐ Pre Diabetes ☐ A1C ____________
☐ Diabetes
☐ Fall Risk/Balance
☐ Cancer

☐ Alzheimers/Dementia
☐ Caregiver Burnout
☐ Tobacco Use
☐ Arthritis
☐ Nutrition Counseling/Healthy Eating

☐ Cardiovascular Disease/Hypertension
☐ Other ____________

Healthcare Provider Signature: Date: / / Notes:

Referrer Information

Referral Date: / / Referrer Name:

Referrer Organization:

Phone: ( ) - Fax number for feedback: ( ) -

Authorization to Disclose Confidential Information about My Chronic Conditions for Better Self-Management Care

I,

(Participant's Name) (Participant's DOB)

hereby voluntarily authorize disclosure of certain information for the purpose of being referred to a chronic disease education/ self-management program or service. Information shared may include my name, address, phone number, date of birth, primary language, health insurance, and health concerns related to the referral. This personal information may be shared between and among the health care provider listed below, the Rhode Island Department of Health, and the chronic condition education /self-management program or services to which I have been referred.

I understand that the health care provider listed above may be provided additional information related to the referral, including whether I participated in the programs to which I was referred and the outcome of my participation.

I also understand that I may revoke this authorization at any time by writing to the healthcare provider who referred me to the programs. If I revoke this authorization my personal healthcare information will no longer be shared and will be protected by federal and state law.

(Signature of person referred) (Date)

Directions

- Please have the person being referred sign the authorization to disclose information to Community Health Network Programs.
- Keep a copy for your records.
- Please fax this form to Community Health Network through secure fax 401-633-6229.
- Please call Community Health Network Patient Navigator at 401-432-7217 if you have any questions.