



Community Health Network Program Referral

Patient Information

Name _____ Gender Male Female

Address _____

Birth Date / /

Program Preference: Morning Afternoon Evening Weekend

Best Phone to call: _____ Best time to call: _____

Currently enrolled in WISEWOMAN? Yes No

Special Accommodations?
Language Spanish Other (Please specify) _____ Physical or other special needs: _____

Primary Insurance: BCBS of RI United Healthcare Neighborhood Health Plan Tufts Medicare

Medicaid (check one): Rite Care ConnectCare Rhody Health None Other _____

Healthcare Provider Information

Provider Name _____ Date / /

Agency / Practice _____ Phone _____ Fax _____

Send feedback to: Same as above or Name: _____

Phone _____ Fax _____

Patient Health Concern (Check all that apply)

- Arthritis
- Asthma
- Cancer Survivor
- COPD
- Fall-risk
- Hypertension
- Pain
- Youth with Special Needs
- Other chronic condition: _____

If one of the below is checked, a Physician, NP, or PA signature is required:

- Nutrition Counseling
- Weight Management
- Diabetes
- Heart Disease
- Pre-Diabetes
- Tobacco Use

Specific Program Request: _____

Patient enrolled in onsite program, CHN Patient Navigator contact not needed. Program Name: _____

Healthcare Provider Signature: _____

Healthcare Provider Notes: _____

- Please have the person being referred sign the authorization to disclose information to Community Health Network Programs.
- Keep a copy for your records.
- Provide the person referred with the Community Health Network Program materials.
- Send this form to Cindy Ariza or Catherine Cabral through secure fax (401-222-4418).**
- Call Cindy Ariza (401-222-7636) or Catherine Cabral (401-222-7623) if you have any questions.**
- The patient progress reports will be emailed or faxed to the number provided on this form.

Department of Health use only:

Date entered	Entered by
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Authorization to Disclose Confidential Information about My Chronic Conditions for Better Self-Management Care

I, _____ (Program Participant) _____ (DOB)
hereby voluntarily authorize disclosure of my name, address, phone number, date of birth and gender for the purpose of my referral to a chronic disease education and/or self-management program or services.

My information is to be disclosed by:

(Name of Referring Practice/Organization)

(Street Address)

(City, State, Zip)

I understand that my personal information (listed above) may be shared only to help me better manage my health and only between and among my referring health care provider, the Rhode Island Department of Health, and individual or community program involved with chronic condition education /self-management program or services to which I have been referred. Information to be shared include letting my referring health care provider know whether I participated in 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. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a later expiration date.

Signature of Person Referred

Date

Expiration Date of Authorization (One year from today, or later if you write a later date above.)

Signature of Authorized Representative of Healthcare Provider

Date

Keep a copy for your records
Provide the person referred with the Community Health Network Program Guide
Send this form to **Cindy Ariza** or **Catherine Cabral** through secure fax (401-222-4418) or
Secure email at (cindy.ariza@health.ri.gov) (Catherine.cabral@health.ri.gov). Call Cindy Ariza 401-222-7636 or
Catherine Cabral 401-222-7623 if you have any questions.