



Community Health Network Program Referral Form

Patient Information

Name: _____ Gender: Male Female Other

Address: _____ City/Town: _____ State: _____ Zip: _____

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

Primary Language: English Spanish Other (Please Specify)

Primary Insurance: BCBS United Healthcare Neighborhood Health Plan Tufts Medicare Medicaid

Currently enrolled in WISEWOMAN? Yes No

Referral Provider Information

Referral Date: / / Provider Name: _____

Practice Address: _____

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

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

Programs available (check all that apply)

Community Health Network

- Asthma Services
- Certified Diabetes Outpatient Educator (CDOE) (Registered Nurse, Dietitians, and Pharmacists)
- Chronic Disease Self-Management Program
- Chronic Pain Self-Management Program
- Diabetes Prevention Program (DPP)
- Diabetes Self-Management Program
- Enhance Fitness Program (YMCA)
- Matter of Balance: Managing Concerns About Falls
- Powerful Tools for Caregiver
- Quit Smoking Support Services

For WISEWOMAN Program Referrals Only

- Gym Membership
Name: _____
- Health Coaching Plus By CDOE or CVDOE
(Registered Dietician, Nurse, and/or Pharmacist)
- Vida Sana
- Weight Loss / Weight Management Program
Name: _____
- Fitness Program
Name: _____

Healthcare Provider Signature: _____ Date: / / Notes: _____

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)

Please have the person being referred sign the authorization to disclose information to Community Health Network Programs.

- Keep a copy for your records. • Fax this form to Community Health Network through secure fax **401-222-4418**.
- Please call Community Health Network Patient Navigator at **401-222-3600** if you have any questions.