



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: _____ Medicaid ID# (From Anchor Card): _____

Gender: Male Female Other Birth Date: / /

Health Concerns

<input type="checkbox"/> Pain	<input type="checkbox"/> Alzheimers/Dementia	<input type="checkbox"/> Cardiovascular Disease/Hypertension
<input type="checkbox"/> Pre Diabetes <input type="checkbox"/> A1C _____	<input type="checkbox"/> Caregiver Burnout	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tobacco Use	_____
<input type="checkbox"/> Fall Risk/Balance	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Nutrition Counseling/Healthy Eating	_____

Referrer Information

Healthcare Provider Referrer Name: _____ Referral Date: / /

Referrer Organization: _____

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

Healthcare Provider Signature:

Authorization to Disclose Confidential Information about My Chronic Conditions for Better Self-Management Care
 (Participant's Name) _____ (Participant's DOB) _____

I 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.