April 3, 2019

Community Health Network **Program Referral Form**

Med-it #

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)

Insurance Information

Health Carrier Plan: ☐ BCBSRI ☐ United Healthcare ☐ Neighborhood Health Plan ☐ Tufts

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

Referral Provider Information

Referral Date: / / Provider Name:

Practice Address:

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

Programs available (check all that apply)

Community Health Network

- ☐ Asthma Services
- ☐ Certified Diabetes Outpatient Educator (CDOE) (Registered Nurse, Dietitians, and Pharmacists)
- ☐ Chronic Pain Self-Management Program
- ☐ Certified Cardiovascular Disease Outpatient Educator (CVDOE)
- ☐ Diabetes Prevention Program (DPP)
- ☐ Diabetes Self-Management Program
- ☐ Matter of Balance: Managing Concerns About Falls
- ☐ Pedaling for Parkinson's
- ☐ Powerful Tools for Caregivers
- ☐ Tools for Healthy Living (Chronic Disease Self-Management Program)
- ☐ Walk with Ease

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: _____
- ☐ **Other Services:** _____

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.
- 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.
- Cut on the dotted line below to provide patient with information to take home.

A Certified Community Health Worker from Rhode Island Parent Information Network (RIPIN) will be reaching out to you on behalf of the Community Health Network within 2 business days of receiving this referral for (Name of program) _____. If you would like to speak with a patient navigator about the program, please call 401-432-7217.