RIPIN Community Health Network Program Referral Form

Patient Information

Name:

Gender: ☐ Male ☐Female ☐Other

Best Contact Phone:

Email:

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

Health Concerns

☐ Know the 10 Signs: Early Detection Matters - Alzheimer's and Dementia
☐ Understanding Alzheimer's and Dementia - Alzheimer's and Dementia
☐ Healthy Living for Your Brain and Body - Alzheimer's and Dementia
☐ Building Foundations of Caregiving - Alzheimer's and Dementia
☐ Supporting Independence - Alzheimer's and Dementia
☐ Communicating Effectively- Alzheimer's and Dementia
☐ Responding to Dementia Related Behaviors- Alzheimer's and Dementia
☐ Exploring Care and Support Services- Alzheimer's and Dementia
☐ LIVESTRONG – Cancer Survivor Fitness
☐ Powerful Tools for Caregiving – Caregiving
☐ Certified Diabetes/Cardiovascular Disease Outpatient Educator Services –Chronic Disease Management
☐ Tools for Healthy Living- Chronic Disease Self-Management
☐ Ready for Health – Diabetes Prevention Program
☐ Matter of Balance: Managing Concerns about Falls – Fall Prevention
☐ Gait Way to Better Balance – Fall Prevention
☐ Tai Ji Quan: Moving for Better Balance – Fall Prevention
☐ Health Heart Ambassadors – Blood Pressure Self-Monitoring Program
☐ Chronic Pain Self-Management – Pain Management
☐ QuitNow Rhode Island- Tobacco and Nicotine Cessation Services

Referrer Information

Healthcare Provider Referrer Name:

Provider NPI:

Referrer Organization:

Referral Date:

Phone:

Fax number for feedback:

Healthcare Provider Signature:

(Date):

Disclosure

- The disclosure of certain information is for the purpose of being referred to a chronic disease education/self-management program or service. Information shared may include patients name, address, phone number, date of birth, primary language, health insurance and health concerns related to the referral. This personal information may be shared with the Rhode Island Department of Health and the chronic condition education/self-management program or services to which the patient is being referred.
- The health care provider listed above may be provided additional information related to the referral including outcome of the referral and program outcome.
- The patient may revoke this authorization at any time by writing to the referring healthcare provider. Personal healthcare information will no longer be shared and will be protected by federal and state law if revoked.

Directions

Scan Me to the CHN

- Referrals can be made by visiting the CHN web page at: www.ripin.org/chn.
- Please fax this form to Community Health Network Secure Fax at: 401-633-6229
- Questions please contact a Community Health Netowrk Patient Navigator at: 401-432-7217
- Keep a copy for your records
- Thank you for your referral. Providers can receive reports and updates on patients they refer to CHN Program.