NH Care PATH
Connections to better living

Date Sent: _____

Date Received: _____
Confirmation from Receiving Entity:
❑ Yes ❑ No

REFERRAL FORM

NH Department of Health & Human Services
Community Long Term Services and Supports

Please fax or email this form to each organization on behalf of the client.

To:	**From:**
Type ❑ DCS DHHS ❑ Area Agency ❑ CMHC ❑ SLRC	**Type** ❑ DCS DHHS ❑ Area Agency ❑ CMHC ❑ SLRC
Reason for referral/Present situation: _____	

Client Name:	**Client DOB:**
Who is contact person for this client? ◉ **Self** ○ **Other** _____	
Address:	**Cell:**
Phone:	**Other:**
Where can we leave a message with the Client: _____	
What is your client's current living situation? ❑ **Homeless/Shelter** ❑ **Independent Living** ❑ **Group Home/Assisted Living**	
Number in the home: ___ Do they have access to transportation? ❑ **Yes** ❑ **No** **If yes, what kind?** _____	

Check All That Apply

Activities of Daily Living: ❑ Eating ❑ Bathing ❑ Dressing ❑ Grooming/Hygiene ❑ Toileting ❑ Mobility (in home and/or out of home) ❑ Positioning ❑ Transferring ❑ Communicating

Instrumental Activities of Daily Living: ❑ Preparing Meals ❑Shopping ❑ Transportation ❑ Housework ❑ Managing Money ❑ Telephone Use ❑ Employment ❑ Medication Management

Any of the Following: ❑ Cognitive Function ❑ Memory Concerns ❑ Communication ❑ Sensory or Motor Disability ❑ Learning Concerns ❑ Judgment and Decision Making Issues ❑ Behavioral Health Concerns
❑ Other: _____

Please list any additional attachments or forms you are sending with this referral: ❑ Level One Screen ❑ 800 application
❑ Agency assessment _____
❑ Other
_____

List any additional information the client would like to share:
_____
_____

THIS AUTHORIZATION IS VALID FOR ONE YEAR AND MAY BE REVOKED AT ANY TIME IN WRITING PRIOR TO THE EXPIRATION DATE, EXCEPT TO THE EXTENT THIS AGENCY HAS ALREADY USED OR DISCLOSED THE INFORMATION IN RELIANCE ON MY AUTHORIZATION.

I UNDERSTAND THAT THE ORGANIZATION I AM RELEASING INFORMATION TO WILL NOT CONDITION TREATMENT ON MY PROVIDING THIS AUTHORIZATION AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION, UNLESS THE TREATMENT INVOLVES RESEARCH, OR IS PERFORMED ONLY FOR THE PURPOSE OF CREATING PROTECTED HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY (SUCH AS INSURANCE PHYSICALS).

I understand that the recipient of information disclosed under this authorization may re-disclose this information, and the information may be protected by federal or state confidentiality laws.

I understand that NH law permits the organization I am signing this form for to charge for the cost of copying the information released under this authorization, up to $15 for the first 30 pages or $.50 page, whichever is greater. (NH RSA 332-I:1)

Patient / Legal Guardian Signature _____ Date _____

RELEASE OF SENSITIVE INFORMATION

I UNDERSTAND THAT MY RECORD MAY CONTAIN SOME INFORMATION IN REFERENCE TO, BUT IS NOT LIMITED TO, DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC TREATMENT, VENEREAL DISEASE, HIV/AIDS TESTING/INFORMATION, HEPATITIS B TESTING OR TREATMENT.

PATIENT/LEGAL GUARDIAN_____ DATE_____