Feel Better Food

Brought to you by The Progress Center, Inc.

Patient Referral Form

Fax Referral: (207) 739-1114
Contact: Liz Blaquiere: (207) 890-5721

Patient Name

Program: Adults: Patient Meal Delivery

Date of Referral

Age

Date of Birth

Gender Male Female

Street Address

City / Town

Cell Phone

Home Phone

Other Household Members:

Name	Age	Relationship	Comments
Name	Age	Relationship	Comments

Name / Phone Number of Person Filling out Form

If patient is a minor Parent Name:

Referring Physician / Provider

Phone

Fax

Reason for Referral

Primary Diagnosis

Secondary Diagnosis

Food Allergies

Dietary Restrictions

Diet Recommendations

Is patient malnourished or at risk of malnourishment?

yes

no

35 Cottage St., Norway, ME 04268 Main: (207) 743-8049 Fax: (207) 739-1114

Release of Information

Full Name: Date of Birth:

I hereby request and authorize staff employed by The Progress Center, Inc. to use or disclose the individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization/individual authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Information to be: (Please check both boxes)	released to obtained from	Provider or Practice Name

Description of Information to be released: (check all that apply)

Diagnosis & Treatment Other: Please Specify:
Discharge Plan
Assessment / Evaluation

Purpose of Release:

Coordination of home delivery meal services

I understand that the information indicated above is protected by law and cannot be released without permission, unless otherwise required by law. I further understand that I may review my records and refuse authorization to disclose all or some of the above health information, but refusal may result in discharge from the home meal program. I may receive a copy of my records.

Information regarding alcohol/drug use or abuse, mental health and/or HIV or AIDS is often necessary to coordinate quality services. By initialing below, you give consent to release the following:

Alcohol / drug use or abuse records
Mental Health records
HIV / AIDS diagnosis / treatment records

I understand that this authorization will expire on the following date _________________________ (not to exceed 1 year from date signed), or upon termination of services. I may revoke this authorization by notifying The Progress Center at any time, except where The Progress Center has already acted upon a request for the release of my health information.

The Progress Center will not receive payment for the use of the information disclosed.

I authorize The Progress Center staff to communicate information regarding my case via email and fax:

Yes
No

I understand that I am entitled to a copy of this form. Client received copy: Yes
No, declined

Patient or Parent / Guardian if Patient is a minor Signature Date: