

WE CARE MANATEE, INC.

PATIENT REFERRAL FORM
Revised 11/2008

TO EXPEDITE: 941-753-1399
BY MAIL: 4808 – 26TH STREET WEST
BRADENTON, FL 34207

Date: _____

Patient Name: _____ Date of Birth: _____
Street Address: _____ City: _____ Zip: _____
Phone Number: _____ Race: _____ Sex: _____
Alternate Contact: _____ Alternate Phone: _____
Social Security Number: _____ Is a Translator Needed: Yes No

Is the Patient receiving Medicaid: Yes No

Is the referral related to a disability claim, unresolved litigation or workman's compensation claim? Yes No

This patient is being referred to We Care Manatee to see a:

_____ for _____
Type of Specialist Requested **Reason-** must be significantly medically necessary
(Cardiologist- needs EKG before being consult can be requested) and cannot be managed or treated by a primary care provider.
(Neurologist/Surgeon- needs MRI before consult can be requested)
(Orthopedic surgeon- needs x-ray before consult can be requested)

*******DOCUMENTATION OF THE PROBLEM/NEED MUST ACCOMPANY THIS REFERRAL-XRAY, SCANS, LABS, NOTES*******

NOTE: Exclusions include, but are not limited to: routine exams or screenings of any type, referrals for diagnostic testing only, medication only, infertility, birth control, cosmetic surgery, physical therapy, disability determination, second opinions, hepatitis, home health care, joint replacement, pain management, sleep studies, unresolved auto accidents, workers compensation or disability cases.

Name of referring Physician, ARNP or PA (PRINT)

Signature of referring Physician, ARNP or PA

Address (PRINT OR STAMP)

Phone

Contact Person other than Physician (REQUIRED)

Fax

Patients are not accepted by the We Care program until eligibility is determined. We Care is a voluntary provider program and is limited by the provider, funds available and is not obligated to provide services to anyone.

THE PATIENT MUST SIGN THE FOLLOWING CONSENT AND RELEASE AUTHORIZATION

I hereby give my informed written consent for all of the partners, as defined below, participating in the We Care Manatee, Inc. program to access and review my patient files including the diagnosis, treatment, prognosis, medical records and/or other information that is acquired during my participation in the program. All participating entities agree to adhere to all of the appropriate and pertinent privacy and confidentiality requirements. The definition of partners will include, but is not limited to: volunteer health care providers, Manatee County Medical Society, Manatee County Government Community Services Department, Florida Department of Health, Manatee Memorial Hospital and Blake Medical Center.

Signature: _____

Printed Name: _____