

**WE CARE MANATEE, INC.**  
**PATIENT REFERRAL FORM**

To expedite processing, referrals can be sent via:  
Fax: 941-753-1399  
Mail: 4808 – 26<sup>th</sup> Street West, Bradenton FL 34207  
or Gulf Coast Health Information Exchange (HIE)

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address (if different): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

- Language Spoken: English Spanish French Creole Other: \_\_\_\_\_
- Does the patient have health insurance of any kind? Yes No
- Is the patient receiving Medicaid? Yes No Share of Cost Amount: \$ \_\_\_\_\_ N/A
- Is the referral related to any of the following: disability determination, unresolved auto accidents, or workers compensation cases, a routine exam, diagnostic testing only, medication only, infertility, birth control, cosmetic surgery, second opinions, hepatitis treatment, or pain management? Yes No

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

\_\_\_\_\_ for \_\_\_\_\_  
**Type of Specialist Requested**  
All Gynecological, Rheumatology & Urology require lab work up  
Cardiologist require EKG  
Neurologist, Neurosurgeon, Orthopedic & Orthopedic surgeon require MRI  
**Reason-** must be significantly medically necessary and cannot be managed or treated by a primary care provider.

**\*\*ALL REFERRALS MUST INCLUDE DOCUMENTATION OF THE NEED, INCOMPLETE REFERRALS WILL BE RETURNED \*\***

\_\_\_\_\_  
Name of Referring Physician, ARNP or PA (PRINT)

\_\_\_\_\_  
Signature of Referring Physician, ARNP or PA

\_\_\_\_\_  
Address (PRINT OR STAMP)

\_\_\_\_\_  
Phone \_\_\_\_\_ Ext. \_\_\_\_\_

\_\_\_\_\_  
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.

**PATIENT MUST SIGN THE FOLLOWING CONSENT AND RELEASE OR THE REFERRAL WILL NOT BE PROCESSED**

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, Lakewood Ranch Medical Center and Blake Medical Center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date Received: \_\_\_\_\_ by: \_\_\_\_\_ Date Processed: \_\_\_\_\_ Revised 4/2011