



Patient Referral Form

To expedite processing, referrals can be sent via:

Fax: 941-870-8503

Mail: 300 Riverside Drive East, Suite 4500
Bradenton, FL 34208

Medical Care For People In Need

Date: _____

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ Zip: _____

Physical Address (if different): _____

Phone Number: _____ Social Security #: _____

Alternate Contact: _____ Alternate Phone: _____

Language Spoken: English Spanish Other: _____

Does the patient have a pending disability case? Yes No

Does the patient have health insurance of any kind? Yes No

Is the patient receiving Medicaid? Yes No Share of Cost Amount: \$ _____ N/A

This patient is being referred to We Care Manatee to see a Specialist (Select ONE):

- | | | |
|---|---|--|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> OTHER (If it is not listed above, it may not be available; however we may know of other options/providers): _____ |
| <input type="checkbox"/> General Surgeon | <input type="checkbox"/> Otolaryngologist (ENT) | |
| <input type="checkbox"/> Gynecological Oncology | <input type="checkbox"/> Orthopedic Surgeon | |
| <input type="checkbox"/> Gynecology | <input type="checkbox"/> Radiology (Breast Health ONLY) | |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Radiation Oncology | |

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 INCLUDING MEDICAL NOTES FROM AN OFFICE VISIT AS WELL AS LABWORK AND/OR NECESSARY TESTING FOR DIAGNOSIS (MRI/XRAY/USN/ETC.) INCOMPLETE REFERRALS WILL BE DENIED****

Name of Referring Physician, ARNP or PA (Print)

Signature of Referring Physician, ARNP or PA

Contact person other than Physician (REQUIRED)

Phone/Fax

Patients are not accepted by the We Care Manatee program until eligibility is determined. We Care Manatee is a volunteer 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 Government Community Services Department, Florida Department of Health, Manatee Memorial Hospital, Lakewood Ranch Medical Center and Blake Medical Center.

Signature: _____ **Date:** _____