We Care Manatee inc.
Medical Care For People In Need

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

Date: _____

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ Zip: _____

Physical Address (if different): _____

Phone Number: _____

Alternate Contact: _____ Alternate Phone: _____

Language Spoken: ☐ English ☐ Spanish ☐ Other: _____

Does the patient have a pending disability case? ☐ Yes ☐ No

If yes, what was it applied for? _____

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

Is the patient receiving Medicaid? ☐ Yes ☐ No ☐ Share of Cost ☐N/A

This patient is being referred to We Care Manatee to see a Specialists (SELECT ONE ONLY):

☐ Cardiology
☐ Cardiothoracic Surgery
☐ Dentistry
☐ Dermatology
☐ EMG Testing
☐ Endocrinology
☐ Gastroenterology
☐ General Surgery
☐ Gynecologic Oncology
☐ Gynecology
☐ Medical Oncology
☐ Nephrology
☐ Neurology
☐ Neurosurgery
☐ Ophthalmology
☐ Optometry
☐ Otolaryngology (ENT)
☐ Pain Management & Therapy
☐ Physical Therapy & Rehab
☐ Plastic/Reconstructive Surgery
☐ Pulmonology
☐ Radiation (Breast Health ONLY)
☐ Radiation Oncology
☐ Urology
☐ Vascular Surgery
☐ Other (If it is not listed above, it may not be available; however, we may know of other options/providers)

_____

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:** _____