Patient Referral Form

To expedite processing, referrals should be sent via fax 941/870-8503
Or Mail to: 300 Riverside Drive East, Suite 4500 Bradenton, FL 34208

We Care Manatee inc.
Medical Care For People In Need

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 **Good County ☐ Yes ☐ No**

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

Patient may be denied if tests positive for illicit drugs- REFERRALS MUST INCLUDE SUPPORTING RECORDS

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

☐ Cardiology
☐ Cardiothoracic Surgery
☐ Dermatology
☐ Gastroenterology
☐ General Surgery
☐ Gynecologic Oncology
☐ Gynecology
☐ Medical Oncology
☐ Nephrology
☐ Neurology
☐ Neurosurgery
☐ Optometry
☐ Otolaryngology (ENT)
☐ Pain Management & Therapy
☐ 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 FOR CONSULT REFERRAL (please be specific regarding reason for consult or treatment requested)

_____

PLEASE INCLUDE:

☐ **Office notes from assessment of condition** ☐ **Physicians order** ☐ **labs** ☐ **other testing (imaging, EKG etc.)**

_____ _____
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 providers, and 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:** _____