Patient Referral Form

Please send completed form and supporting documents via fax 941-870-8503

We Care Manatee inc.
Medical Care For People In Need

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ Zip: _____

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, including Medicaid? ☐ Yes ☐ No ☐ Share of Cost

Good County ☐ Yes ☐ No

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

☐ Breast Health
☐ Cardiology
☐ Colorectal Surgery (Colonoscopies, etc)
☐ Dermatology
☐ Gastroenterology
☐ General Surgery
☐ Gynecologic Oncology
☐ Gynecology
☐ Medical Oncology
☐ Nephrology
☐ Neurology
☐ Neurosurgery
☐ Optometry
☐ Otolaryngology (ENT)
☐ Pain Management & Therapy
☐ Plastic/Reconstructive Surgery
☐ Podiatry
☐ Pulmonology
☐ 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)
_____

PLEASE INCLUDE:

☐ **Office notes from assessment of condition** ☐ **Physician order** ☐ **Labs** ☐ **(Imaging, EKG etc.)**

Diagnosis: _____

_____
Name of Referring Physician, ARNP or PA (Print)

_____
Signature of Referring Physician, ARNP or PA

_____
Contact person other than Physician (REQUIRED)

_____ / _____
Phone Fax

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

PATIENTS SHOULD BE INFORMED OF THE FOLLOWING

Referral is being requested through **We Care Manatee Volunteer Health Care Provider Program**. Each referral will be reviewed for required information. Patients are not accepted into the program until eligibility (income & residency) is determined. **All specialists are volunteers, and care cannot be guaranteed.**

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: We Care Manatee, volunteer health care providers, Manatee County Government Public Safety Department, Florida Department of Health, Manatee Memorial Hospital, Lakewood Ranch Medical Center and Blake Medical Center.

Does We Care Manatee have your permission to send you (the patient) text messages with appointment information and application requirements? ☐ Yes ☐ No

Signature: _____ **Date:** _____