We Care Physician Referral Network
Office: (352) 334-7926/Fax: (352) 334-8844

Equal Access Clinic

Patient Referral & Information Form

Please complete and fax to (352) 334-8844
Please confirm receipt of faxed information by telephone.

Date: _____ **Referring Physician:** _____

Please indicate urgency of referral: Routine ☐ Urgent ☐ Expedite ☐

Patient Name:
_____

Address: _____ City/State/Zip:
_____

Home phone: (____)_____ Work phone: (____)_____

Date of Birth: ____/____/____ SS#: _____/____/_____ Sex: ____ Race:
_____

Specialty or Service Requested: _____
(This field is required)

Reason for referral: _____

Has patient already been referred to a specialist? Yes ☐ No ☐

If yes, to whom: _____
_____

Please attach all relevant medical records (labs, diagnostic study reports, patient notes, etc.) if referral is for specialty care outside of referring physician office

Person completing form: _____

Phone: (_____)_____ Fax: (_____)_____

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Referral Status: **Approved** ☐ **Appointment:** _____
Denied ☐

Notes:
_____

For We Care Use: Date:_____ **Action:** Send PEA:___, Send Call Letter:___, File:___,
Close Case:___, Fax Status to Originator:___, Request Medical Records:___,
TPC & Schedule:_____within_____, Schedule with:_____