



8390 N. Palafox Street
Pensacola, Florida 32534

Escambia We Care

A Volunteer Medical Community Program

Telephone: 850.484.5082
Fax: 850.484.5153

We Care Physician Referral

Please Print-COMplete ALL BLANKS

Patient's Name

Date of Birth

Social Security Number

Address

Telephone Number (No long distance numbers accepted)

City, State, Zip Code

Cell Phone Number (No long distance numbers accepted)

Mailing Address – If Different From Residence

Address

City

State

Zip Code

Referred By:

Physician's Name

Office Contact Person

Address

Telephone Number

City, State, Zip Code

Fax Number

Reason for Referral:

Self referral

Specialty Patient Referred To: _____

Reason for the Referral: _____

urgent

Specialists may refer patients to We Care and continue providing their care. No backup documentation is required for a specialty physician "self-referral". If this is a physician self-referral, please check the box above marked "self referral."

Back-up documentation enclosed, if not a self-referral (please check):

_____ Recent Progress Notes _____ Recent Lab Results _____ Recent Radiology Results _____ Other

Referring Physician's Signature

Date

This referral form, along with appropriate documentation may be faxed to 850.484.5153 and/or mailed to the We Care office:

Escambia County Health Department
We Care Program
8390 N. Palafox Street
Pensacola, Florida 32534

