BayCares Referral Request

DATE:_____

Please fax referrals to:
BayCares Program
(850) 818-0911

Patient Information

Patient Name:	Race:	Sex:	DOB: (Must be over 18)
Mailing Address:	City:		Zip:
Phone Number:	Social Security Number:		

Specialty or Diagnostic Requested: _____

Reason for Referral: (Cannot be Managed/Treated by a Primary Care Provider)

_____

True	False	Please Select "True" or "False"
		The Patient is a resident of one of the following counties: Bay, Franklin, Gulf, Calhoun, Holmes, Jackson, Liberty, Wakulla, Walton or Washington
		The patient has no insurance or coverage that will pay for requested care.
		The Patient is a US Citizen.

Patients are not accepted by the BayCares Program until Eligibility is determined.
BayCares is a volunteer program and is limited by the provider and funds available.

ATTACH ANY DIAGNOSTIC TESTING AND ALL MEDICAL RECORDS AND OFFICE NOTES TO REFERRAL

Referral Authorization:

Referring Facility: _____

Contact Person: _____

Phone: _____

Fax: _____

Physician Name: _____

Physician Title: _____

X_____
Physician Signature

Date: _____