BayCares, Inc.

CONNECTING PATIENTS TO SPECIALISTS WHO CARE

CLIENT REFERRAL FORM

Patient must be between the ages of 18 and 64 and must not have health Insurance of any kind.

PATIENT NAME:_____

RACE:_____ SEX:_____ DOB:_____

PHONE NUMBER:_____

ADDRESS:_____

CITY:_____ ZIP:_____ CIRCLE COUNTY:

Bay, Calhoun, Franklin, Gulf, Holmes, Jackson, Liberty, Wakulla, Walton, Washington

Please Indicate Specialty Requested: _____

Reason for Referral: _____

(Cannot be managed by Primary Care Provider)

REFERRAL AUTHORIZATION:

REFERRING FACILITY: _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____

PHYSICIAN NAME: _____

X_____

PHYSICIAN SIGNATURE

Fax Referrals to 850.818.0911

Attach any diagnostic testing, medical records and office notes.