Flagler Free Clinic
For People. Not for Profit.

FRONT DESK REFERRAL

Referring Provider_____

Date:_____

Order #:_____

Patient Label

Department of Health (DOH):

- **GYN Childbearing years:**
- **GYN Ages 50 – 64:**
  - Application given to patient on (date):_____
- **Diabetic Education:**
- **HIV:**
- **Hepatitis C:**

Flagler County Human Services:

- **Specialist**_____
  - Application given to patient on (date):_____

Impower Mental Health:

- Impower Authorization signed on (date):_____
(Patient's email address required)

Internal Provider Referral (Name)_____

External Provider Referral (Name)_____