Flagler Free Clinic
For People. Not for Profit.

DH1032

<u>BE SURE TO RECORD THE REASON FOR THE VISIT ON THE DOCUMENT</u>. If not recorded, every patient file has to be looked up to view provider's notes.

1. Be sure to GET THE REASON FOR VISIT on the form. Follow up is not acceptable. Ask the patient what they are being treated for if follow up is their answer. Are they here to get test results? Is it related to diabetes, blood pressure, thyroid, medication refill, pain etc. Something more specific must be recorded in a few words.

2. Have the patient sign and date the form after the reason is recorded.

3. A 110 must also sign and date the form.

4. When complete, make a copy and give the patient the copy. Place the original in the black bin at the front desk for scanning.

Revised 10/4/21

Florida HEALTH

VOLUNTEER HEALTH CARE PROVIDER PROGRAM
PATIENT REFERRAL FORM

Referral #

NOTICE TO PATIENT

You are being referred to a volunteer health care provider who will provide free care to you or someone for whom you are legally responsible. Depending on the determination of the volunteer health care provider, you may also receive services from pathologists, laboratories, radiologists, and anesthesiologists. Your participation in this referral process is voluntary. The care you receive from the volunteer health care professionals will be provided at no charge to you. However, you may be billed for pharmaceuticals. The health care providers are providing care on behalf of the State of Florida and each serves as an agent of the State. By acceptance of this referral, you acknowledge that the state solely is liable for any injury or damage suffered by you, or someone that you permit to receive treatment, that results from authorized treatment by the volunteer providers and that the State's liability is limited as found in section 768.28, Florida Statutes (copy provided)

I hereby certify that I have read the above notice and understand that I am being referred to a volunteer health care provider who will provide free care for me or someone for whom I am legally responsible. I further understand the volunteer health care provider may also refer me to pathologists, laboratories, radiologists, and anesthesiologists whose specialized services may be needed to treat my health condition. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and whomever she/he may designate as assistants). In addition, I certify that the information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge.

I also acknowledge I am responsible to inform the clinic of any change in my financial or health insurance status.

2.

Signature: _____ Date: _____

If treatment is for a minor, indicate relationship to child

Patient's Name: Date of Birth:

Address: Sex: Male ☐ Female ☐

Race: White ☐ Black ☐ Asian/PI ☐ Am Indian/Alaskan Native ☐

Phone: Ethnicity: Hispanic ☐ Non-Hispanic ☐

Eligibility: *(check one)* ☐ DOH client/patient ☐ 200% poverty or less ☐ Medicaid eligible *(no provider available)*

Referral Type: Medical Care ☐ Dental Care ☐ Other *(specify)*

3.

Notes:

_____
Print Name of DOH Referring Person

1.

_____ _____
DOH Referring Person's Signature Date

Referred to: FCFC

Address/Phone:

As needed, the above-named health care provider is referring this patient to the following health care providers who are under contract as outlined in section 766.1115, Florida Statutes, and are agents of the state:

Pathologist Laboratory Radiologist Anesthesiologist

Response to Referral Originator:
(actual services provided)

Date of Initial Service Received _____

Estimated Value of Health Care Provided $

_____ _____
Volunteer Health Care Provider Signature Date

☑ In lieu of signature, see progress notes.

DH 1032 (12/14), 64I-2.002(5), F.A.C.

ORIGINAL-To Patient Medical Record COPY-To Patient at Time of Referral
COPY-To Provider as Needed