



# WE CARE

A VOLUNTEER MEDICAL COMMUNITY PROGRAM



1295 West Fairfield Drive  
Pensacola, Florida 32501

Telephone (850) 595-6775  
Fax (850) 595-6691

## Physician Referral

### Please Print

\_\_\_\_\_  
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:

Specialty Patient Referred To: \_\_\_\_\_

Reason for the Referral: \_\_\_\_\_

**Specialist may refer patients to WE CARE and continue providing their care. No backup documentation is required for a specialist's "self-referral". If this is a self-referral please indicate that on the line above marked "Specialty patient referred to:"**

Back-up documentation enclosed (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) 595-6691 and/or mailed to the WE CARE office:**

**Escambia County Health Department  
WE CARE Program  
1295 West Fairfield Drive  
Pensacola, Florida 32501**