



For Office Use Only:

Doctor: _____

Number: _____

Patient Encounter Form Dr. Diebel Jr. Memorial

☐ New Patient ☐ Returning Patient

☐ General Visit ☐ Specialty Visit

Date of Visit: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Sex: M ☐ F ☐

Date of Birth: **Month** ____/____ **Day** ____/____ **Year** ____

LANGUAGE: ☐ English ☐ Spanish ☐ Portuguese ☐ Creole ☐ Vietnamese ☐ Other _____

RACE: ☐ White ☐ Black/African American ☐ Asian ☐ Other _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Name of Contact: _____

Email: _____ Alternate Phone #: _____

REFERRED BY: ☐ AdventHealth ☐ Orlando Health ☐ Dr's. Office ☐ Health Dept. ☐ Community Clinic (PCAN) ☐ Church

☐ Central FL Regional ☐ Nemours ☐ Shepherd's Hope staff/website ☐ Friend ☐ Other _____

Reason for Visit: _____

FINANCIAL STATUS: ☐ Employed _____ ☐ Unemployed ☐ Child ☐ Student ☐ Retired ☐ Homeless

For Scribe Use Only

☐ Lab Work Ordered

☐ Radiology Test Ordered

☐ Specimen Collected

☐ Medications Prescribed

☐ Follow Up Exam Referred to: _____

☐ Same clinic Specialist /specialty(s): _____

☐ Recheck at clinic When: _____ Week/s _____ Month/s

☐ Referred to PCAN

☐ Discharged to PCAN



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.

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: <i>(check one)</i>	DOH client/patient	200% poverty or less	Medicaid eligible <i>(no provider available)</i>
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Referral Type:	Medical Care	Dental Care	Other <i>(specify)</i>
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Notes: _____
Print Name of DOH Referring Person

DOH Referring Person's Signature Date

Referred to:

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
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Response to Referral Originator: <i>(actual services provided)</i>	Date of Initial Service Received _____
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Estimated Value of Health Care Provided \$

Volunteer Health Care Provider Signature Date

☐ In lieu of signature, see progress notes.