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**

Entered By: _____ Date: / /

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

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

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

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.

Hepatitis C Questionnaire

Patient Name: _____ DOB: _____ / _____ / _____

Current symptoms (check all that apply):

☐ Abdominal Pain ☐ Vomiting ☐ Jaundice ☐ Loss of Appetite ☐ None

☐ Fever ☐ Nausea ☐ Headache ☐ Diarrhea

History (check all that apply):

Have you received vaccinations for: ☐ Hepatitis A ☐ Hepatitis B ☐ Neither ☐ Unknown

Have you previously had: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Unknown

Have you received a blood transfusion before July 1992? ☐ Yes ☐ No ☐ Unknown

Have you worked in the medical field involving direct contact with blood? ☐ Yes ☐ No

Risks (check all that apply):

☐ IV drug use

☐ Incarceration in prison / jail

☐ Household contact of a person with Hepatitis C

☐ Tattoos

☐ Sex partner with known Hep C

☐ Shared needles for any reason

☐ Opioid use

☐ HIV/AIDs coinfection

☐ Body piercing (in the last year)

☐ None apply