

# Patient Referral Form

## Charitable Health Care Provider Program

### NOTICE TO PATIENT

It is intended that you are being referred to a charitable (volunteer) health care provider who will provide care to you or for someone for whom you are legally responsible. Your participation in this referral process is voluntary. Depending on the determination of the charitable (volunteer) health care provider, you may also receive services from pathologists, laboratories, radiologists, and anesthesiologists. The care you receive from a volunteer health care professional will be provided at no charge to you. However, you may be billed for hospital, pharmaceuticals, laboratory services, or other associated services connected with your care, only the services of the health care professional you are being referred to will be at no charge. It is your responsibility to ask and determine what charges or financial responsibility you will have for any services other than those of the Charitable health Care Provider. The Charitable Health Care Provider is providing care on behalf of the State of Oklahoma and 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 provider and that State's liability is limited as provided in Oklahoma law in the Governmental Tort Claims Act, 51 O.S. §§ 151 *et seq*, as amended.

I hereby certify that I have read the above notice and understand that it is intended that I be referred to a charitable (volunteer) health care provider who will provide care for me or someone for whom i am legally responsible. I further understand that charitable (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.

Patient/Guardian Signature:

Date:

If treatment for a minor child, indicate relationship to child:

For Referring Clinic Use:

Referring Free Clinic Name

Name of Referring Provider:

Patient's Information:

Name:

Date  
of Birth

Address:

City:

State:

ZIP Code:

Phone Number:

Sex

Race

Ethnicity

Male

White

Hispanic

Female

Black

Non-Hispanic

Asian/PI

American Indian/

Alaskan Native

Referral Type:

Select one per  
referral form:

Pathologist

Dentist

Laboratory

Behavioral Health Professional

Radiologist

Pharmacist

Anesthesiologist

Other

Other (please  
specify)

Reason for  
referral:

Do you have notes regarding this referral?

Notes: If yes,  
please attach to  
referral.

Yes

No

Referring Provider Signature or Designee:

Date:

As needed, the above-named health care provider is intending to refer this patient to a charitable health care provider who is under contract as provided at 51 O.S. Supplement 2007, Section 152.2.

Information for Specialist Receiving Referral:

Appointment Date and Time:

Name of  
Specialist:

Date:

Address:

Time:

City:

State:

ZIP Code:

Phone Number:

Response to Referring Provider  
(actual services provided by specialist)

Diagnosis/treatment provided:

Date(s) of Services Rendered:

Estimated Value of Health Care Provided:

(Receiving) Volunteer Specialist Provider

Date:

Please print this form. Signatures by the patient/guardian and the referring provider/  
designee must be in place for referral to be valid.