Patient Referral Form

This form should be used for patients without insurance who may be eligible for the County Indigent Program provided by Big Bend Health. Completing this form does not guarantee coverage for the patient. The patient will be contacted within 3 business days by the Big Bend Health office to screen for eligibility.

Client Information:

Client name:		Phone Number:
County of Residence: ☐ Brewster ☐ Presidio	Client Date of Birth:	Client Primary Language: ☐ English ☐ Spanish ☐ Other:

(Provider use):

To:	Big Bend Regional Hospital District	Fax:	432-837-3261
From:		Provider's Phone:	

(Provider use) **Reason for referral:**

(Provider use) **Services needed:**

☐ Medical Plan	Assistance paying for preventative and emergency medical care, includes medications
☐ Medical case management	Assistance in coordinating and scheduling medical appointments

I (*client's name*), _____, understand that the information provided on this form will be released to Big Bend Regional Hospital District. I give my permission for this referral to be made and information to be released. I understand that this information is confidential.

_____ _____

(Client signature) (Date)