BROOKINGS
behavioral health & wellness

REFERRAL FORM

From: _____ *(provider)*

Ph: _____ **Fax: _____**

Patient Name: _____

Ph: _____ **DOB: _____**

Referral Reason: _____ Medication Management

_____ Mental Health Counseling

_____ Chemical Dependency Counseling

_____

_____

_____

_____

Please attached the following:

____ Evaluation (within last 6 months)
____ Last Progress Note
____ Medication List

Please fax referral and documents to (605) 697-2874

Brookings Behavioral Health & Wellness will call the patient to set all appointments. Any questions, please call (605) 697-2850.

Thank you for your referral.

211 Fourth Street | Brookings, SD 57006 | 605.697.2850 | 605.697.2874