



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.

This information contained in this transmission is privileged and confidential information intended only for use of the individual or entity named above. If you have received this communication in error, please call (605) 697-2850 IMMEDIATELY and destroy this fax.
Thank You.