# The Well Psychiatric Care

Patient Referral Form

Please fax completed form to: 620-206-9932

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Date _____

Patient Name _____

Patient DOB ____/____/_____

Patient Phone (____) _____-_____

Patient Address_____

City _____ Zip _____

Patient email address _____

Referring Provider _____

Notes _____

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The Well Psychiatric Care
823 North Main St., Ste 1
McPherson, KS 67460
(620)220-1225