**Referral Form Southern Plains Behavioral Health Services**

**500 E. 9th Str.**

**Winner, SD 57580**

**Phone: 842-1465 Fax: 842-2366**

Person taking referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time:\_\_\_\_\_\_\_\_

Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M/F Mother’s first name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person calling in referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. making referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic/Hospital making referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client aware this referral is being made? Yes\_\_ No\_\_ Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Fax last progress note, history, physical and med list)\_\_\_\_

Who is the Guardian? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are they aware of the referral? Yes\_\_\_ No\_\_\_

Anticipated Payment Source:

\_\_\_ Title XIX \_\_\_Contract \_\_\_Self Pay/Private \_\_\_Other 3rd party

Nature of Problem:

What school does the student attend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of service needed Therapy\_\_\_\_\_\_\_\_\_\_ Med mgmt \_\_\_\_\_\_\_\_\_\_Both \_\_\_\_\_\_\_

Currently on any medications? Y/N If yes, please list medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Medication?\_\_\_\_\_\_ If so, start date:\_\_\_\_\_\_\_ Medication and Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client needs psych evaluation and medication adjustment Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Client History: Noncompliant with meds: Yes\_\_\_ No\_\_\_ History of Medication Abuse: Yes\_\_\_\_\_ No\_\_\_\_\_

Contact made by and date:

Updated 09/2016