Referral Form

Southern Plains Behavioral Health Services
500 E. 9th Str.
Winner, SD 57580
Phone: 842-1465 Fax: 842-2366

Person taking referral: _____ Date: _____

Name of Client:_____

Mailing Address: _____Phone Number: _____

Social Security number: _____Date of birth: _____

Sex: M/F Mother's first name: _____

Person making referral:_____

Is the client aware this referral is being made? Yes __ No__

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: _____

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

_____

Contact made by and date: _____

_____

_____

Updated 7/28/2014