Health Care Referral Form

Patient Information

Name: ______________________ **Date:** ______________________

Address: ______________________ **Language Spoken:** ______________________

Date of Birth: ______________________ **Interpreter Needed:** Yes ☐ No ☐ Uncertain ☐

Contact No.: ______________________

Referral Source Information

Agency: ______________________ **Phone No.** ______________________

Referral Source Contact Person ______________________ **Fax No.:** ______________________

Reason for Referral: ______________________

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Patient Aware of Referral: Yes ☐ No ☐

For Office Use Only

Appt. Scheduled: ______________________ **Patient No.:** ______________________

Please fax referral form to (605) 367-8211.
For urgent situations, please call Sarah at (605) 367-8212 or Janson at (605) 367-8041.

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