SHERIDAN MEMORIAL HOSPITAL
Behavioral Health

1333 West 5th Street, Suite 200 | Sheridan, WY 82801
307.675.2674 | Fax: 307.675.5896
sheridanhospital.org

Behavioral Health Clinic Referral Form

Date of Referral: ______________________________

Referral Source

Referring Provider Name ____________________ Agency ____________________ Contact Phone # ___________________

Patient Demographics

Patient's name ____

DOB ____________________________________ Sex ______ Race _________________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address (include zip code) ____

Home Phone # ___________________ Cell Phone # ___________________ Social Security Number ___________________

Insurance Type/Name: ____________________________________ Member ID: ____________________________________

Emergency Contact Name and Phone Number: ____

PCP: __________________________________ Clinic Name: _________________________ Phone: _____________________

Reason for referral

____

____

Diagnosis: ____

Relevant Medical Diagnosis': ____

Relevant Social Factors: ____

Past Psychiatric history and treatment: ____

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Current Psychiatric Medication list: ____

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Signature of referral source: ____ Date: _____________________________

Please fax information to Behavioral Health at 307.675.5896

Please send any relevant documentation and a copy of patient's insurance card.

To serve our community with excellent patient-centered care