Referrals

(External Referrals to Promise Healthcare)

Please Complete the below information

Date: ____/___/_____

To: Promise Healthcare

Please send completed form or call the applicable department (contact information provided below)

Subject Line: **Attention:** New Patient Referrals

☐ **Mental Health Services** (Psych/Behavioral health, Counseling)
- Email: integratedservices@promisehealth.org
- Phone: 217-600-7000 Ask for Care Coordinator.

☐ **Substance Abuse Treatment** (Individual Therapy, Group Therapy)
- Email: integratedservices@promisehealth.org
- Phone: 217-600-7000 Ask for Care Coordinator

☐ **Medical Services** (Primary Care Services)
- Email: integratedservices@promisehealth.org
- Phone: 217-600-7000 Ask for Care Coordinator

☐ **Dental Services** (Cleanings, fillings, emergency services, routine dental services)
- Email: integratedservices@promisehealth.org
- Phone: 217-600-7000 Ask for Care Coordinator

From:_____

Contact Information:_____

Patient Name:_____ **Date of Birth:** _____/_____/_____

Grade (if applicable):_____ **Insurance Provider (if known):**_____

Parent or Guardian name(s): _____

(***Parent info is required for Dental – for minors 0-18 years, recommended for all other referrals for minors)**

Address:_____

City:_____ **State:**_____ **ZIP:**_____

Phone number (home/Cell/Other): _____ **Email:**_____

Preferred Promise Location:_____

Referral Reason/Notes:_____

Received by:_____ **Date Received:**_____/_____/_____

STAFF USE ONLY