Wellness 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: mentalhealthwellness@promisehealth.org
- Phone: 217-403-5433

☐ **Medical Services** (Primary Care Services)
- Email: medicalwellness@promisehealth.org
- Phone: 217-356-1558

☐ **Dental Services** (Cleanings, fillings, emergency services, routine dental services)
- Email: dentalreferrals@promisehealth.org
- Phone: 217-356-1558

From:_____

Contact Information:_____

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

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

Parent or Guardian name(s):_____
(**Parent info is not required if 12 years or older and do not wish for parents to be informed**)

Address:_____

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

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

Preferred Promise Location:_____

Referral Reason/Notes:_____

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

STAFF USE ONLY

Form Committee Approved 02.20.25