Wiconi Wakan Health & Healing Center
P.O. Box 719 Rosebud, South Dakota
57570

605-747-2777

Referral Form

_____ _____ Date:_____
Person Completing Referral Relationship to Client

Program (Circle one) : ACF JDC IHS TCSD SFIS WRSD Tiwahe Glu Kini Pi
Tokala Inajinyo CHR Other _____
Phone/Address/ of person referring:_____
Guardian Aware of Referral: Y/N Date Guardian Notified:_____

_____ _____ _____
Person Being Referred DOB School/Grade

Reason for Referral:
_____

Concerns: ___Abuse/Trauma ___Attendance/Tardiness ___Grief
___Anger ___Behavioral Issues/Defiance ___Family/Relational
___Anxiety ___Depression ___Substance Use
___Suicidal Thoughts ___Homicidal Thoughts
Other/Nonviolent concerns
_____
Exposure to Violence(abuse, neglect,self harm,suicide,domestic violence,etc):_____
_____

_____ Phone:_____
Mother/Guardian

_____
Father/Guardian Phone:_____

_____
Address

Directions to home:_____

Signature of person(s) Making Referral_____

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Please fax completed referral form to 605-747-5412 or email to wiconiwakan@rst-nsn.gov