Psychiatric Assessment & Treatment Referral

Please fax the following information to: **Referral Care Team at 333-3037**

Client Name: **Date of Birth:** **Gender: M /F** **Class Member: Y / N**

Address: **City:** **Zip:**

Guardian: ________________ **Phone:** ________________ **Can we leave a message** Y / N

Interpreter Services needed: **Client:** Y / N **Guardian** Y / N **Language spoken:**

Primary Insurance:________________ **Secondary Insurance:**________________

Group Number: ________________ Group Number: ________________

Identification number:________________ Identification number:________________

Phone #:________________ Phone Number:________________

Referral Source/Name:________________ **Organization:**________________

Phone:________________**Fax:**________________ **Email:**________________

How did you hear about us? :

If you are referring from a physician's office, please attach the latest visit summary to this referral form.

Current Therapist: ________________ **Phone:**________________

Current Case Manager:________________ **Organization:**________________ **Phone:**________________

Please indicate the Psychiatric Provider of preference*

** Please note that every effort is made to accommodate preferences, however the client may be scheduled with another provider.*

Lewiston: ___ Lisa A. Pomerleau, PMHNP (Children & Adults)
___ Christine Plourde-Rand, APRN, PMH-NP

Portland ____ Paula Urbach, NP

Bangor: ____ Jessica, Arsenault, MD *(Children & Adolescents only)*
_____Deborah Pickering PMHNP *(Adults)*
______ Michelle LaCombe, PMHNP

Bar Harbor: ____ Kati DeRevere, NP *(Adults)*

Augusta: ____ HAM Case Management *Clients only Telepsych)*

Ellsworth: ____ Kati DeRevere, NP *(Adults)*

Is client aware of this referral: Y / N **Is the client in crisis? Y / N** **Was crisis information given? Y / N**

Diagnosis: **Current Symptoms:**

Current or history of violence or aggression: Y / N Please explain –

Current or past substance abuse: Y / N Please explain –

Current Psychiatric Medications and dosage: (attach list if needed) **Name of Prescription:**	**Dosage:**	**Prescribing MD/NP:**

Client name:____________________________

Suicide attempts: Y / N

Previous Psychiatric Hospitalizations: Hospital	**Date**	**Reason for Hospitalization**

Current or Previous Psychiatrists Name:	**Year:**

Medical History

Current Non-Psychiatric Medications and dosage: Name of Prescription:	**Dosage:**	**Prescribing MD/NP:**

Allergies
Current Medical Issues (including recent surgeries)**:**

Screening Notes: ***Office Use Only***

OFFICE USE ONLY

Date Referral Received: ___________________ ***Date Insurance Verified:*** ____________________ ***Initials:*** __________

Full Mainecare: Y / N Limited Mainecare: Y / N Non Categorical: Y / N Medicare: Y / N QMB: Y / N

Please note: Insurance was verified on the date listed above through the Mainecare verification line. The clinician who accepts this referral assumes responsibility for verifying this information with the client and with Insurance Company at start of services and no less than once monthly.

Revised 08/25/15, 11/19/19