Outpatient Referral Form

Please fax the following information to: **Referral Care Team at** 207-**333-3037**

If you would like the team to confirm placement please check here ☐

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

Address:

Home Phone: **Cell Phone:** **Permission to leave a message: Y / N**

Guardian Name: **Home Phone:** **Cell Phone:**

School-Based Counseling: Y / N **School:**

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

Referral source name: **Organization:** **Phone:**

Email Address: **How did you hear about us? :**

Brief description of issues/concerns:

Mental Health: ___

Substance Abuse: ___

Co-Occurring: ___

Safety concerns (Domestic Violence, Anger/Aggression): Y / N **Legal Issues: Y / N**

If Yes, please specify: **If yes, please specify:**

Is the client in crisis? Y / N **Was crisis information given? Y / N**

Counseling Preferences

Times **better** for Client	Days that **do not** work for client	Type of therapy	**Telehealth**	Gender
Mornings / Afternoons	**M T W Th F S**	_____	**Y / N**	**M / F**

Please ask about Telehealth. A convenient & confidential service providing counseling services right from the privacy your home via webcam video conferencing.

** Insurance Information – *Please be sure to complete all information* **

Primary Insurance:_____	**Secondary Insurance:_____**
Group Number: _____	Group Number: _____
Identification number:_____	Identification number:_____
Phone #:_____	Phone Number:_____
Prior Auth required? Y / N	Prior Auth required? Y / N

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**	**Quimby: Y / N**
Clinician Referred to:		***Date:***

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.