Health Affiliates Maine

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)*
____ Joyce Petrosky, PMHNP-BC (Adolescents & Adults)
____ Deborah Pickering, NP *(Adults)*

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:**

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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.