



Integrated Outpatient Services – Referral Form

Date of Referral: ____/____/20____

Referred By: _____

Phone No: _____

Client Information – Fill Out All Information Completely

Name: _____ DOB: ____/____/____ SS# ____ - ____ - ____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Ok, to leave message? Yes / No

Parent/Guardian Name: _____

Parent/Guardian Address (if different): _____

Parent/Guardian Telephone (if different): Home: _____ Work: _____ Cell: _____

Male Female, Marital Status (circle one): **Single Married Separated Divorced**

Employed: YES NO Occupation: _____ **Student?:** YES NO

Current school and educational level or highest grade achieved: _____

Current medications, (including over-the-counter) and known drug reactions: _____

_____ **Known allergies:** _____

Who prescribed medication? _____

Name, telephone and address of next of Kin: _____

Statement of Concern/Problem:

Reason for seeking service: _____

Desired outcome(s) of service: _____

Use of substances: Yes No If yes, what: _____

How often: _____

Please complete all forms in black ink.

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Previous mental health services? Yes N When? _____
Where? _____

Present or past safety concerns (i.e. suicidal, homicidal..): Yes No
If yes, describe: _____

Primary care doctor: _____ Phone: _____

*****9-1-1 or 774-HELP (888-568-112)*****

Insurance (Please get complete insurance information)

MaineCare Private Insurance Medicare Secondary Insurance Self-Pay Other _____

Primary Insurance: _____ Policy Holders SS#: ____-____-_____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____

Client's Relationship to Policy Holder (circle one): **SELF SPOUSE CHILD OTHER**

Prior authorization obtained (if required): Yes No

Secondary Insurance: _____ Policy Holders SS#: ____-____-_____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____

Client's Relationship to Policy Holder (circle one): **SELF SPOUSE CHILD OTHER**

Prior authorization obtained (if required): Yes No

Additional Information

Additional Notes: _____

Days/Times Preferred: _____

Meets criteria for admission: Yes No

If NO, was referral offered: Yes No **If YES, complete intake log.**

Referral taken by: _____

Logged on Intake and Referral Form: Yes No Logged by: _____

Please complete this form in black or blue ink.

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