Crisis & Counseling Centers
10 Caldwell Rd., Augusta, Maine 04330-5735

Date: _____

OUTPATIENT REFERRAL FORM

PLEASE SEND ALL CORRESPONDENCE TO P.O. BOX 558, AUGUSTA, ME 04332-0558 OR FAX TO 207.626.3453

Client Name: _____ **DOB:** _____ ☐Male ☐Female **SS#** *(last 4)* _____

Mailing Address: _____ **Town/State/Zip:** _____

Home Phone # _____ **Cell #** _____ **Class Member:** ☐Yes ☐No

☐Leave non-identifying message with person/machine ☐Leave **no** message

Guardian: ☐Yes ☐No ***If yes***, *Name:* _____ *Phone#* _____

Emergency Contact: *(Name & Relationship)* _____ **Phone #** _____

Permission to contact insurance for Prior Approval? ☐Yes ☐No

Primary Insurance Co: _____ ***Policy ID#*** _____

Secondary Insurance Co: _____ ***Policy ID#*** _____

PROGRAM BEING REFERRED TO: ☐**MENTAL HEALTH** ☐**MEDICATION MANAGEMENT**

SUBSTANCE ABUSE *(PLEASE CHECK ONE)* ☐**EVAL** ☐**OP TX** ☐**IOP** ☐**IOP/PPP** *(MEPP ONLY)*

CASE MANAGEMENT: *(PLEASE SPECIFY)* ☐**ME MOTHER'S NETWORK** ☐**CHILDREN'S**

Referral Source: *(Name/Agency)* _____ **Phone #** _____

***ATTACH ALL REQUIRED RELEASES TO THIS REFERRAL FORM**

Reason for Referral: *(Presenting Problem, Clinical Rationale, Diagnosis if known; attach any relevant reports/information that may help with this referral including an assessment if one has been completed.)* _____

_____

_____

_____

_____

Has the client received Mental Health, Substance Abuse, Medication Management, or Case Management services from any other agencies <u>within the past year</u>? ☐Yes ☐No

<u>If yes</u>, *what service(s)? What agency(s)? Discharge date(s)?:* _____

_____

Does the client have any immediate safety concerns that may request immediate/crisis services? ☐Yes ☐No

If yes, *action taken:* _____

Crisis Number given? ☐Yes ☐No ***If no,*** *explain* _____

<u>For DHHS Referrals only</u>:* If client is not MaineCare eligible, or has lost MaineCare coverage, include the services requested by DHHS for Prior Authorization (PA):** ***(Note: *A separate PA will be required for the LOCA and Treatment)*

Prior Authorization # _____ **MACWIS ID#** _____

Service: *(check one)* ☐Assessment: H2000 ☐Outpatient Treatment (OP): H0004 ☐Intensive Outpatient Treatment (IOP): H0015

Number of Units Authorized: *(check one)*
- ☐Assessment: 8 units
- ☐OP Treatment: 48 units
- ☐IOP Treatment: 576 units

Typical Time Frame Authorized: *(check one)*
- ☐Assessment: 30 days
- ☐OP Treatment: 90 days
- ☐Matrix IOP: 16 weeks

NPI-Site# *(check one)*
- ☐Auburn SA – 022
- ☐Augusta MH – 013
- ☐Augusta SA – 014
- ☐Rockland SA – 023
- ☐Skowhegan MH – 019
- ☐Skowhegan SA – 018

Transportation to be provided by: _____