Dedicated to Hope, Healing and Recovery
10 Caldwell Rd, Augusta, ME 04330-5735
Phone # 207-626-3448 Fax # 207-626-3453

REFERRAL FORM

Name: ______________________ **DOB:** __________ **Date:** __________

Gender (by insurance)**:** ☐Male ☐Female **Gender Identity:** ☐Cis Male ☐Cis Female ☐Trans Male ☐Trans Female ☐Non-binary ☐Other: __________

Address *(St/Rd/Apt#)*: ______________________ **Town/Zip:** __________

Mailing Address *(if different)*: ______________________

Phone *(please check preferred #)* ☐**Home #** __________ ☐**Cell #** __________

Email Address: ______________________

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

Any Special Accommodations? ______________________

Permission to contact insurance for Prior Approval? ☐Yes ☐No ☐Not Reported

Primary Insurance: ______________________ **Policy ID#** __________

Secondary Insurance: ______________________ **Policy ID#** __________

Program being referred to: Outpatient Treatment services: ☐Mental Health ☐Substance Use Disorder

☐Medication Management **Preferred Site/Location:** ☐Augusta ☐Rockland ☐Skowhegan

☐**OPTIONS** *(Overdose Prevention Thru Intense Outreach, Naloxone and Safety – Kennebec & Somerset)*

☐Community Integration services **Diagnoses:** __________

Targeted Case Management services: *(please only specify one)* **Diagnoses:** __________

☐Children *(Behavior Health, Developmental Disabilities & Chronic Medical Care Needs)*

☐PATH *(Projects for Assistance in Transition from Homelessness)*

☐Parents *(with Substance Use Disorder diagnosis & minor children)*

Referral Source: ______________________ **Phone #** __________

Reason for Referral: Current Injection Drug User? ☐Yes ☐No Currently pregnant? ☐Yes ☐No

Presenting Problem/Clinical Rationale: ______________________

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Is the client currently receiving, or has received in the last year, any behavioral health services? ☐Yes ☐No

If yes, what service(s); agency(s); admit date(s); discharge date(s)? __________

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Currently has MAT/MAR Provider? ☐Yes ☐No **If yes,** provider/agency name? __________

Does client have any immediate safety concerns that may require immediate crisis services? ☐Yes ☐No

If yes, action taken? ______________________

Crisis number given? ☐Yes ☐No ***If no,*** *explain* ______________________

DHHS referrals only: *(Prior Authorization required for referrals)* **MACWIS #** __________

NPI Site # Augusta ☐MH-013 ☐SUD/IOP-014 Rockland ☐MH-025 ☐SUD-023 Skowhegan ☐MH-019 ☐SUD/IOP-018

Service Authorized	# of Units/Timeframe	PA #
☐Assessment-H2000	8 units / 30 days	CFS__________
☐Outpatient Tx-H0004	48 units/ 90 days	CFS__________
☐Intensive Outpatient-H0015	49 units/ 49 days	CFS__________

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