Crisis & Counseling Centers

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 (per insurance)**:** ☐Male ☐Female

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 ☐Skowhegan

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

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

☐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: _____

_____

_____

_____

_____

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)? _____

_____

Currently has Methadone Provider? ☐Yes ☐No

If 'Yes', provider/clinic 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: If client does not have full MaineCare or they are receiving services elsewhere, we will need an authorization of payment to proceed with scheduling. Please make sure this is in place prior to sending the referral.