Alternative Wellness Services

Referral Form

Providing services to Southern, Central and Midcoast Maine.

Mailing Address: PO BOX 1565 Biddeford, ME 04005 Phone: (207) 494-8010 x1 FAX: (207) 494-8471

Referral Date:________ **Referent:**________ **Referent Phone:**________

Applicant Name:________ **DOB:**________ **SSN:** ________

Private Insurance:________ **Mainecare #:**________ Full ☐ Limited ☐ No Mainecare ☐

Applicant Physical Address:________ **Mailing**: ________

City:________ **State: ME** **Zip:** ________

Phone:________ **Leave Messages?** ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Transgender **Class Member**: ☐ Yes ☐ No

Veteran: ☐ Yes ☐ No Does the client have a guardian? ☐ Yes ☐ No

Please identify any Special Needs: ________

Level of Education:________ **Primary Language:**________ **Need for Interpreter**: ☐ Yes ☐ No

Religion:________ **Country of Birth:**________ **Ethnicity:** ☐ Non-Hispanic / Latino ☐ Hispanic / Latino

Race:

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American

☐ Native Hawaiian/Other Pacific Islander ☐ Refused ☐ White ☐ Unknown

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

What area are you seeking services in?

☐ Southern Maine ☐ Greater Portland ☐ Central Maine ☐ Midcoast Maine

What services are you interested in?

☐ Case Management ☐ Skills Development ☐ DLSS

☐ Outpatient Therapy (***outpatient is only available in Biddeford or Portland***)

If the following is completed by a diagnosing provider please be sure to **sign and date** inside this box.

Axis I: ________ Axis I: ________

Axis II: ________

Axis III: ________

Axis IV: ________

Axis V: ________

Diagnosing Clinician name (printed): ________ Date: ________

Signature (with credentials): ________

REASON FOR REFERRAL (please be specific about why the client is appropriate for services): ______________________

____

History of psychiatric hospitalizations (Dates, hospitals and reasons): ______________________

____

Substance Use/Abuse History (Including onset and date of last use):

____

Substances Used: ______________________

Frequency: ______________________

Substances Used: ______________________

Frequency: ______________________

What services are you currently receiving? ______________________

PCP: ______________________ **Phone**: ______________________

Case Manager: ______________________ **Phone**: ______________________

Therapist: ______________________ **Phone**: ______________________

Psychiatrist: ______________________ **Phone**: ______________________

Emergency Contact Name: ______________________ **Phone**: ______________________ **Relationship:** ______________________

Address: ______________________

Guardian: ______________________ **Phone:** ______________________

Does the individual have a legal history? ☐ Yes ☐ No If, yes please include charges and dates ______________________

____

Is there anything that would prevent the client from participating in this service (substance abuse, medical issues, etc)

____

What goals would you like to address with our services: *(Narrative):*

How would these goals improve your mental health? *(Narrative):*

Supports: *(Current natural supports involved in recovery telephone #.)*

Medical History/Conditions/Concerns: *(Major medical conditions, surgeries, allergies, etc.)*

Additional Information:

To schedule an intake, please follow up with: ☐ Referent ☐ Client

If being completed by a provider please fax this referral and your psychosocial assessment, treatment plan and completed LOCUS form to (207) 494-8471. You will receive a call back to schedule an intake within 24 hours.