**Mental Health Service Requested:** Case Management  1:1  DLSS/Skills  DBT

**Substance Use Service Requested:** 1:1  IOP  OHH  DEEP Eval/Treatment  other

**Currently receiving this service from another provider?**  Yes  No **I would like to meet:**  Virtually  In Person

**If making this referral on behalf of someone else, please enter your contact information here:** Click or tap here to enter text.

## Client Demographics

**Full Name:** Click or tap here to enter text. **Gender:** Click or tap here to enter text.

**Birth Date:** Click or tap here to enter text. **Social Security Number:** Click or tap here to enter text.

**Address:** Click or tap here to enter text. **City:** Click or tap here to enter text. **State:** ME **ZIP:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text. **E-mail:** Click or tap here to enter text.

**Guardian:** Click or tap here to enter text. **Relationship to Client:** Click or tap here to enter text.

**Guardian Phone Number:** Click or tap here to enter text. **Address:** Click or tap here to enter text.

**Emergency Contact:** Click or tap here to enter text. **Relationship to Client:** Click or tap here to enter text.

**Emergency Phone Number:** Click or tap here to enter text. **Address:** Click or tap here to enter text.

**Primary Language:** Click or tap here to enter text. **Needs an interpreter:**  Yes  No

**Marital Status:** Click or tap here to enter text. **Veteran:**  Yes  No

## Insurance Information

**MaineCare:**  Full  QMB **Member Number:** Click or tap here to enter text.  None/Self-Pay

**Medicare:**  A  B  Supplement **Member Number:** Click or tap here to enter text.

**Private:**

**Policy Number:** Click or tap here to enter text. **Group Number:** Click or tap here to enter text.

**Insurance Address:** Click or tap here to enter text. **Insurance Phone:** Click or tap here to enter text.

**Guarantor:** Click or tap here to enter text. **Guarantor SS#:** Click or tap here to enter text.

## Diagnosis Information

**Current Diagnosis/Code:** Click or tap here to enter text. **Date last seen for this diagnosis:** Click or tap here to enter text.

**Diagnosing Clinician:** Click or tap here to enter text. **Diagnosing Clinician Phone:** Click or tap here to enter text.

## Needs and History

**Reasons for requesting services/Current symptoms/Current situation:** Click or tap here to enter text.

**Safety Concerns:**  Yes  No **Details:** Click or tap here to enter text.

**Substance use history:**  Yes  No **Details:** Click or tap here to enter text.

**Legal history:**  Yes  No **Details:** Click or tap here to enter text.

**Child protective services history:**  Yes  No **Details:** Click or tap here to enter text.

**Other providers/agencies involved:** Click or tap here to enter text.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  | | --- | | ***OFFICE USE ONLY*** | | **Date Referral Received: \_\_\_/\_\_\_/\_\_\_ Date Insurance Verified: \_\_\_/\_\_\_/\_\_\_ Initials: \_\_\_\_\_\_\_\_** | | **Full Mainecare: Y / N Provider Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_** | | **Dual Provider issue: Y / N 3-way call with client & APS made on: \_\_\_/\_\_\_/\_\_\_ Issue Resolved: Y / N** | |