UCP of Maine Referral Form

Please email all referrals to jared.dolley@ucpofmaine.org or fax to 207-941-2955

Client Name: _____ Date: _____

Full Home Address: _____ Phone #: _____

Email Address: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female ☐ Other: _____

Referral Source: _____ Phone #: _____

Email Address: _____

Referring for:

☐ Adult Case Management ☐ Behavioral Health Home (BHH) ☐ Children's Case Management

☐ Bridges Services: ☐ *RCS Specialized School* ☐ *RCS School* ☐ *Day Treatment* ☐ *FBA* ☐ *Outpatient Therapy* ☐ *Preschool (Private Pay)*

☐ Home & Community Treatment (HCT) ☐ Rehabilitative and Community Supports (RCS)

☐ RCS Specialized (In Home) ☐ Outpatient Counseling: ☐ *Individual* ☐ *Group* ☐ *Family* ☐ *Assessment* ☐ *Vineland-3*
☐ *OPT School:* _____ ☐ *Telehealth*

Mainecare Number (if different/additional insurance, see page 2): _____

Diagnostic Assessment: ☐ Yes ☐ No Completed by: _____ Date: _____

Diagnosis: _____

For BHH and Children's Case Management referrals, please provide a copy of a current diagnosis confirmed within the last 12 months, or please list contact information for your records department: _____

Reason for referral (symptoms, behaviors, type of treatment or provider requested):

Please identify role and who has legal custody/guardianship to consent to treatment in left column:

Guardianship Ex: Parent, DHHS, Foster	Name	Address	Contact Number	Ok to leave message?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

For Outpatient Counseling clients only: Do you have transportation to appointments? ☐ Yes ☐ No

What days and times are you available to attend appointments?: _____

Providers/Collateral Contacts: (Emergency Contacts, PCP, Evaluators, Agency Providers, etc.)

Name: _____ Address: _____ Phone #: _____

Name: _____ Address: _____ Phone #: _____

Telehealth Contact (For Telehealth OPT only)

Client/Caregiver Name	Relationship to Client (if applicable)	Email Address

Emergency Contact Info: (By location of Telehealth sessions)

Name: _____ Relationship to Client: _____ Phone #: _____

Telehealth Location: _____ Preferred Emergency Room: _____

Name: _____ Relationship to Client: _____ Phone #: _____

Telehealth Location: _____ Preferred Emergency Room: _____

Additional Insurance Information

Primary:

Primary Insurance: _____ Primary Insurance Phone Number: _____

Policy Holder Name: _____ Member ID Number: _____

Secondary:

Secondary Insurance: _____ Secondary Insurance Phone Number: _____

Policy Holder Name: _____ Member ID Number: _____