

Referral Form

Please email all referrals to referrals@ucpofmaine.org or fax to (207) 941-2955



Client Name: _____ Date: ____/____/____
 Date of Birth: ____/____/____ Phone: _____ Email: _____
 Street Address: _____ Apt #: _____ Town: _____ State: _____
 Sex: Male Female Other: _____
 Completed by: _____ Role: _____ Phone: _____

Referring For:

- Adult Case Management Behavioral Health Home (BHH) Children's Case Management
 Bridges Services: RCS Specialized School RCS School Day Treatment FBA Preschool (Private Pay)
 Outpatient Counseling: Individual Family Vineland 3 Telehealth Face-To-Face
 OPT School: _____

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

Diagnostic Assessment: Yes No Completed by: _____ Date: ____/____/____

Diagnosis: _____

For BHH & Children's Case Management, 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 request):

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

Guardianship Parent, DHHS, Foster, etc.	Name	Address	Phone Number	Ok to leave message?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

For Outpatient Counseling Clients only: Do you have transportation to appointments: Yes No
 What days & times are you available to attend appointments: _____

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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: _____