|  |
| --- |
| **REFERRAL**  |
| **Referral Date**  |  | **Time**  |  |
|  |
| **Referral by** |  | **Phone** |  | **Fax** |  | **Mail** |  |  **Walk In** |
| PERSONAL INFORMATION |
| **Client Name** |  |
|  ***Last Name First Name Middle Name*** |
| **Client Address** |  |
|  |
| **Home Phone** |  | **Cell**  |  |
|  |
| **Parent #1 /Guardian Name**  |  |
| **Phone** |  | **E-mail** |  |
|  |
| **Sole Custody** |  | **Yes** |  | **No** |  |
| **SHARED CUSTODY** |
| **Name**  |  |
| **Phone** |  | **E-mail** |  |
| **DHHS CUSTODY** |
| **DHHS Contact** |  | **Phone** |  |
|  |
| **Social Security** |  | **Date of Birth** |  |
|  |
| **Age** |  | **Sex**  |  | **Male** |  | **Female**  |  | **InterSex** |
| **Preferred Pronouns** |  | **She, Her, Hers** |  | **He, Him, His** |  | **They, Them, Theirs** |
| **SERVICES** |
|  |
| **Service****Requested** |  | **Adult O/P**  |  | **Child O/P**  |  |  **\*HCT USE** **STATE FORM** |  | **TCM** |
| **DX** |  |
| **Services to be provided** |  | **Client’s Home** |  | **Office** |  | **Either** |
| **Person placing referral** |  **Mom** | **Tel** |  |
| **OFFICE USE ONLY** |
| **MaineCare #** |  |
| **MaineCare Verified**  | **(Initial)**  | **Date**  |  |
| **CLIENT NEEDS** |
| **Does the client / family feel this is a crisis?** |  | **Yes**  |  | **No** |
|  |
| **Are crisis services needed?** |  | **Yes** |  | **No** |
|  |
| **FOR ADULTS** |
| **Are you considering harming others?** |  | **Yes** |  | **No** |
| **Are you considering harming yourself?** |  | **Yes** |  | **No** |
|  |
| **Reason seeking services:**  |
| **Outcome desired by client/family:** |
|  |
| **Is this child involved w/ special education services?** |  | **Yes** |  | **No** |
|  |
| **Does the client currently have a Case Manager?** **If “yes”, please provide information below.** |  | **Yes** |  | **No**  |
|  |
| **Case Manager** |  |  **Email** |  |
| **Case Management Agency** |  |
| **Agency Address** |  |
| **Agency Phone** |  |
| **Other Phone Info** |  |
|  |
| **Signature of Person****Taking the Referral** |  X |