

 **REFERRAL REQUEST FORM** *(for Providers)*

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| Referent:       Tel:       Date:       Facility/Provider:       Address:       E-mail address (for referral follow up):        |

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| ***Patient Information:***Last Name:       First Name       Middle Initial:      Gender: [ ]  Male [ ]  Female Transgender [ ]  M/F [ ]  F/M [ ]  Class Member  DOB:       SS#:       MaineCare #:       Address:       City:       State/Zip code:      Home Phone:       Work/Cell:       Parent/Guardian name & contact:        Primary language spoken:       Interpreter needed: [ ]  Yes [ ]  No  |
| ***Service Requested:***Reason for Referral:       Service Requested:       Current Diagnosis (please complete attached DX form):        |
| ***Primary Care Provider:***Physician/NP:       Address:       State/Zip Code:       Tel#:       Fax:       Email Address :       ***Mental Health Provider:***Clinician & credentials:       Address:       State/Zip Code:       Tel#:       Fax:       Email Address:        |

**Clinical Diagnosis Form**

**(MUST BE COMPLETED BY LICENCED CLINICIAN)**

Please refer to the attached release of information allowing you to provide your client's most recent mental health diagnosis to assist to determine eligibility, make necessary referrals and coordinate ongoing services. In order to qualify for case management services, a client must have a Primary Mental Health Diagnosis that is considered active within one year from today's date. This is time-sensitive and we appreciate your prompt response.

Client's full Name**:**      DOB:

**Primary Mental Health Diagnosis & Description**

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| **Code:**      **Des**cription:      **Code:**      **Des**cription:       |

**Date of Diagnosis:**

MUST BE WITHIN ONE YEAR FROM TODAY’S DATE – MUT BE CURRENY DX.

**Other Disorders of Clinical Attention:**

**Name & Credentials of Clinician:**

**Name of Organizatio**n:

Clinician's Signature:

*Signature Date:*

***If Clinician is conditionally licensed, Signature of Supervisor****:*

***Please Fax referral with DX back to Hope For All Community Services LLC, 207-835-0027.***

***Email*** ***hopeforallcs@gmail.com*** ***to follow up on referral.***