MAINE BEHAVIORAL HEALTHCARE

ADMIN Record No.:_____

CASE MANAGEMENT EXTERNAL REFERRAL

DATE OF REFERRAL: _____

REFERRAL FOR (Circle one) Child Adult Case Management Grant Funded Community Integration

Is client aware of the contact?□ **YES** □ **NO** Is it okay to contact client?□ **YES** □ **NO**

PREFERRED LOCATION: Belfast Biddeford Brunswick Damariscotta Norway Portland Rockland Springvale

CONTACT INFORMATION

CLIENT NAME Last: _____First: _____ MI: ____

Address:_____

Phone Number(s): _____

Date of Birth: _____ Social Security Number: _____

Parent/Guardian Name: _____Relationship to Client: _____

Address: _____

Phone Number(s): _____ Okay to leave a message? □ YES □ NO

Special calling instructions (language type if necessary): _____

Is the Client a Class Decree Member? □ YES □ NO □ UNDETERMINED

INSURANCE INFORMATION

Does the Client have Insurance? □ YES □ NO Insurer (s): _____

Policy Number: _____ Private Insurance Group Number: _____

Phone Number:_____ Primary Policy Holder: _____

CLINICAL INFORMATION

Diagnoses	Date	Description	Code
Primary Diagnosis	_____	_____	_____
Secondary Diagnosis	_____	_____	_____

Date of diagnosis _____ By Whom _____

Circle the appropriate services the client needs assistance getting connected to.

Medical Coordination/ Referrals		**Linkage to Financial Resources**		**Linkage to Mental Health Resources**		**Coordination with Other Providers**		**Basic Needs**
Dental	Specialists	Food Stamps	General Assistance	Therapy	ACT	DHHS	Attorney	Housing
PCP	Nursing Home	TANF	SSDI	Psychiatry	ACCESS	School	Home Health	Food
Assisted Living	Other	SSI	Other	HCT	Other	Immigration	Other	Clothing

List 3 mental health symptoms that are currently preventing the client from accessing the resources, ID'd above, independently.

1. _____
2. _____
3. _____

REFERRED BY: Print Name _____ Tel No:_____ Fax No:_____