

## REFERRAL FORM

Date of Referral: \_\_\_\_\_ Referral Source: \_\_\_\_\_

### Service Requested

MENTAL HEALTH  SUBSTANCE ABUSE  DEEP  IOP \_\_\_\_\_

\_\_\_\_\_ Adult                      \_\_\_\_\_ Adult                      Eval \_\_\_\_\_                      SA Grp \_\_\_\_\_  
\_\_\_\_\_ Child                      \_\_\_\_\_ Child                      Trmt \_\_\_\_\_

Location: \_\_Bangor\_\_ Hampden\_\_ Ellsworth\_\_ Waterville

### Referral Information:

Clients Name: \_\_\_\_\_

Clients Date of Birth: \_\_\_\_\_

Clients Phone Number: \_\_\_\_\_

### Method of Payment

Mainecare # \_\_\_\_\_  Medicare  
# \_\_\_\_\_

Private Ins (type) \_\_\_\_\_  Self-Pay \$ \_\_\_\_\_  
Ins Id: \_\_\_\_\_ Group #: \_\_\_\_\_

ADDITIONAL INFORMATION: