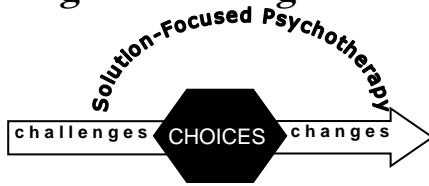


*Dirigo Counseling Clinic*



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## REFERRAL FORM

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

Location:  Bangor  Hampden  Ellsworth

### Service Requested

MH:  SA:  DEEP:  IOP:  CIS:  BHH:  SKILLS:

Adult:  Child  Male Counselor  Female Counselor

### Referral Information:

Clients Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Clients Address: \_\_\_\_\_

Clients Phone Number: \_\_\_\_\_ Text OK: /Land line:

### Method of Payment

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

Anthem: ID \_\_\_\_\_ gr: \_\_\_\_\_

MCHO: ID \_\_\_\_\_ gr: \_\_\_\_\_

Self Pay: \_\_\_\_\_

APPOINTMENT: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Clinician: \_\_\_\_\_