TRUE CONNECTIONS
BEHAVIORAL HEALTH SERVICES

Referral Form

Thank you for your referral. Our agency will contact you to confirm that the referral has been received. We will contact the client to schedule an appointment.

Referral Type

☐ Psychiatric Medication Management Services

☐ Substance Use Counseling

☐ Mental Health Counseling

☐ Medication Assisted Treatment

☐ Case Management Services

Referral Date:_______________ Referral Contact Phone:____________________ Referral Fax: ____________________

Referral Source (Name and Agency):____

Referral Address:____
Referral Source Email: ____

Client Name:____ Date of Birth:________________

Address(Mailing and Physical): ____

Home Phone Number: __________________________________ Cell Phone Number: _____________________________

Email Address: ____

Guardian/Parent Name: __________________________________ Guardian Parent Phone #: ______________________

Interpreter Needed: ☐ Yes ☐ No

Permission to Leave A Message: ☐ Yes ☐ No

Name of Insurance: ____ Policy ID#: ___________________________

Group #: ________________________________ Phone #: ____

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Reason for Referral/Presenting Concerns/comments (attached additional pages if needed: ____________________

Diagnosis if Known: ____________________

List of Current Medications: ____________________

Variables (Please include recent hospitalizations/crisis, incarceration, violent or aggressive behavior, contagious medical conditions, criminal history, risk to self or other, pertinent safety issues): ____________________

Other Provider/Services Names: ____________________

Other Information (best time to contact, living conditions, etc.…): ____________________

Signature of Person Making Referral: ____________________ Date: ____________

Office Use Only

Date Referral Received: ____________ Time Received: ____________

Insurance Verification Information: ____________________

Date Verified: ____________ Verified By: ____________

Send to: PO Box 175, Lincoln, ME. 04457
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