



TRUE CONNECTIONS

BEHAVIORAL HEALTH SERVICES

REFERRAL FORM

We will acknowledge receipt within two business days and contact the client or guardian regarding next steps.

A referral does not guarantee admission. This form is not for emergencies; call 911 or 988.

1 SERVICES REQUESTED - CHECK ALL THAT APPLY

- | | |
|--|--|
| ☐ Psychiatric Medication Management | ☐ Medication-Assisted Treatment |
| ☐ Mental Health Counseling | ☐ Substance Use Counseling |
| ☐ Children's Case Management | ☐ Adult Case Management |
| ☐ DEEP Services | ☐ Recovery Coaching |

2 REFERRAL SOURCE

REFERRAL DATE	REFERRING PERSON	TITLE / ROLE
ORGANIZATION / AGENCY	PHONE	FAX
SECURE EMAIL	REFERRAL SOURCE ADDRESS	

3 CLIENT AND PARENT / GUARDIAN INFORMATION

LEGAL NAME	PREFERRED NAME	DATE OF BIRTH	
MAILING / PHYSICAL ADDRESS	CITY, STATE, ZIP		
PRIMARY PHONE	ALTERNATE PHONE	EMAIL	BEST CONTACT TIME
LEAVE VOICEMAIL:	☐ Yes ☐ No	SEND TEXT:	☐ Yes ☐ No
INTERPRETER NEEDED:	☐ Yes ☐ No	LANGUAGE OR COMMUNICATION NEED	
PARENT / GUARDIAN NAME - IF APPLICABLE	RELATIONSHIP	PHONE	

4 INSURANCE INFORMATION

PRIMARY INSURANCE	MEMBER / POLICY ID	GROUP NUMBER	INSURANCE PHONE
SUBSCRIBER NAME - IF DIFFERENT	SUBSCRIBER DOB	SECONDARY INSURANCE	

5 REFERRAL INFORMATION

REASON FOR REFERRAL, PRESENTING CONCERNS, AND GOALS

DIAGNOSIS OR DIAGNOSES - IF KNOWN

CURRENT MEDICATIONS - OR ATTACH A CURRENT MEDICATION LIST

6 CLINICAL, SAFETY, AND ACCESS CONSIDERATIONS

Include recent crisis or hospitalization, current risk to self or others, violence or aggression, legal involvement, medical needs, or accessibility needs that are relevant to safe and appropriate service delivery.

7 CURRENT PROVIDERS AND SUPPORTS

PROVIDER / AGENCY NAMES, SERVICES, AND CONTACT INFORMATION

8 CLIENT AWARENESS AND SUPPORTING DOCUMENTS

CLIENT / GUARDIAN IS AWARE OF THIS REFERRAL: ☐ Yes ☐ No

ATTACHED - CHECK ALL THAT APPLY:

☐ Medication list ☐ Recent assessment ☐ Discharge summary ☐ Release of information ☐ Insurance card

OTHER RELEVANT INFORMATION - LIVING SITUATION, BARRIERS, PREFERENCES, OR OTHER DETAILS

9 REFERRER ATTESTATION

I confirm that the information is accurate to the best of my knowledge and that awareness of the referral is indicated above.

REFERRING PERSON'S SIGNATURE - TYPE OR SIGN

DATE

HOW TO RETURN THIS FORM

Secure email: referrals@trueconnectionsme.org

Secure fax: 207-521-8555

Mail: PO Box 175, Lincoln, ME 04457

Send PHI only through secure/encrypted email, secure fax, or mail. Do not use ordinary unencrypted email.

10 OFFICE USE ONLY

DATE RECEIVED

TIME RECEIVED

RECEIVED BY

VERIFIED

BY