Maine Behavioral Health Organization

MBHO Referral Form

Referral Type: ☐TCM ☐CIS ☐Counseling ☐Med Management
☐ Substance Abuse ☐ RCS Section 28 ☐ Behavioral Health Home
☐All Services-Adult ☐All Services-Children

Client Full Name:	DOB:	Social Security #:		
Insurance:		Policy Number:		
Physical Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Mental Health Diagnosis:		Axis II:		
Axis III:		GAF:		
Diagnosed by whom and when:		Date:		
Guardian Name:		Guardian Phone #:		
Interpreter needed? ☐Yes ☐No				
Home Phone Number: ( )		Cell Phone Number: ( )		
Permission to leave a message? ☐Yes ☐No				
Referral Source Name/Organization:				
Referral Source Address:	City:	State:	Zip:	
Referral Source Contact Info: Phone: ( )		Cell: ( )	Fax: ( )	
Referral Source email address: _____				
Reason for Referral for Services:				
Dangerous variables (***please include recent crisis/hospitalizations, incarcerations, violent or aggressive behavior, contagious medical conditions, criminal history, risk to self or others or other pertinent safety issues***) :				
Mental Health Provider Names:				
Other Information (***best time to contact, client information needed before intake, 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: 49 Oak St. Augusta Me 04330 FAX 207 626-8312 or FAX 207-474-5244				