COMMUNITY CHOICE
BEHAVIORAL HEALTH

Referral Form

Client Information

Client Full Name: _____

DOB: _____ Gender: _____ Class Member: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Permission to leave a message? ☐ Y ☐ N

Guardian Name: _____

Guardian Home Phone: _____ Guardian Cell Phone: _____

Interpreter services needed?: ☐ Y ☐ N Language spoken by client?: _____

Referral Source Information

Is this a self-referral? ☐ Y ☐ N

Organization: _____ Address: _____

Phone: _____ Fax: _____ Email: _____

Refferant Name: _____

Service requested:

☐ Outpatient Therapy ☐ Case Management

Safety concerns (Domestic Violence, Anger/Aggression)? ☐ Y ☐ N

If yes, please specify: _____

Substance Abuse? ☐ Y ☐ N

If yes, please specify: _____

Legal Issues? ☐ Y ☐ N Is the client in crisis? ☐ Y ☐ N Was crisis information given? ☐ Y ☐ N

Preffered Provider: _____

Diagnosis Information

Is there a known current diagnosis? ☐ Y ☐ N

Primary Diagnosis

Diagnostic Code: _____ **Diagnostic Name:** _____

Secondary Diagnosis

Diagnostic Code: _____ **Diagnostic Name:** _____

Diagnosing Clinician: _____ **Date of current diagnosis** _____

Other disorders of clinical attention:

Insurance Information

Insurance/MaineCare ID #: _____ **Social Security Number:** _____

PLEASE FAX COMPLETED FORM TO:

Community Choice Behavioral Health LLC.

207-640-4474

Date Referral Received: _____
(Office Use Only)