

Referral Form

Name: _____ Phone Number(s): _____; _____

If unable to contact me directly, it is ok to leave a message at the phone number/s that I provided: Yes ___ No ___

Address: _____ Town _____ ZIP: _____

DOB: _____ Age: _____ M/F: _____ Social Security # _____ Marital Status: _____

Parent/Legal Guardian: _____ Phone Number(s): _____; _____

Address _____ Town _____ ZIP: _____

Are you a Class Member Yes ___ No ___ (A Class Member is a person who was hospitalized at AMHI/Riverview since 1990)

Do you have MaineCare? Yes ___ No ___ MaineCare# _____

Do you have Medicare? Yes ___ No ___ Medicare # _____

Will you be paying out of pocket for the service/s? Yes ___ No ___ if Yes, please call for rates @364-3549

Do you have private health insurance? Yes ___ No ___

If so, does your insurance cover this type of service? Yes ___ No ___

Name of Private Health Insurance Company: _____

Address of Insurance Company: _____ State _____

ZIP: _____ Phone # _____

Subscriber's Name: _____ Relationship to client: _____

Policy # _____ Group # _____

This referral is for the following services, check all that apply:

Outpatient Therapy

Case Management

In Home Support Services (DLSS)

Name of person making the referral, if other than self: _____

Agency Name: _____ Phone _____

Is the potential client aware of this referral? Yes ___ No ___

Note the reason(s) for referral/areas of concern:
