MaineGeneral
Community Care

Behavioral Health Services

Intake Form

(Please fax completed form to one of the programs listed below)

ACT Team ☐ ***Fax**: (207) 621-3702* **Women's Residential** ☐ **Fax**: (207) 621-7240

Outpatient Counseling ☐ Substance Use ☐ Mental Health ☐ Mental Health Co-Occurring ☐

Fax: (207) 621-3771

Date of Referral: ______________________________ **Referring Provider:** __________________________________

Referring Mailing Address: ____

Phone Number: _____________________________ **Fax Number:** ________________________________

Client Name:

Last___________________________First_______________________Middle______________Maiden____________

Date of Birth: _________ **Social Security Number:** __________ - _____- ____________

Mailing Address: **County** ___________________________

City/Town ____ State________ Postal Code __________

Physical Address, if different from mailing address:

City/Town ____ State _______ Postal Code ___________

Primary Phone Number: __________________________ **Secondary Phone Number:** ________________________

Class Member: Yes☐ No☐

Have you ever received services here before: Yes☐ No☐

Living Arrangements:

Unhoused ☐ Alone ☐ Lives with family ☐ Homeless shelter ☐ PNMI ☐

Other (please specify) ____

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Sex at Birth:

Male ☐ Female ☐ Other ☐

Identified Gender: Male ☐ Female ☐ Other ☐

Sexual Orientation:

Heterosexual ☐ Bisexual ☐ Asexual ☐ Homosexual ☐ Other ☐

Marital Status:

Single ☐ Married ☐ Divorced ☐ Separated, legally ☐ Widowed ☐ Life Partner ☐ Civil Union ☐ Unknown ☐

Ethnicity:

Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Patient declined to answer ☐ Patient not present ☐

Race:

White ☐ Black ☐ Native or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐

American Indian ☐ Some mixture of two or more of these groups ☐ Other ☐

Guardian Name/Mailing Address (if, applicable): ____

City/Town ____ State ___________ Postal Code ___________

(*Please attach guardianship paperwork for records*) Yes☐ No☐

(if, No please explain) ____________________________

Created: January 21, 2021

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Emergency Contact:

Name: ____ Relationship to Client: __________________________

Mailing Address: (Physical Address, if different from mailing address)

City/Town ____ State _____________ Postal Code _________________

Primary Phone Number: ___________________________ Secondary Phone Number: ________________________

Pregnant: Yes☐ No☐ (if, Pregnant): IV Drug User? Yes☐ No☐ **OR** Substance Use Disorder? Yes☐ No☐

Open Case with DHHS Office of Child and Family Services? Yes☐ No☐ (if yes, please specify below)

____

Primary Care Provider/Practice Name/Address: ____

Phone Number: __________________________ Fax Number: ____________________________

Allergies (Medication/Food/Latex)? Yes☐ No☐ (if yes, please attach a list)

Special Accommodations Required? Yes☐ No☐ Handicap ☐ Interpreter ☐
Other (please specify) ____

DSM V Diagnostic Codes and Title: (Please attach most recent evaluation/assessment)

Current Medications: (Please attach most recent medication sheet)

Current Medical Status/Conditions: (please specify below)

____

Insurance Information:

No INS ☐ Self Pay ☐ MaineCare ☐ Medicare ☐ Commercial ☐ SA Reduced Fee ☐
Other, specify________________________________

Subscriber: _________________________________ Guarantor: ____

Policy Number: ______________________________Group Number: _______________________________________

Provide copy of Insurance Card? Yes/No (if No, please explain) ____

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Number in Household: __________________

Household Income: $____________________ **Declined to give Household Income** ☐

Please complete this section for ACT Referrals only

Email: actteamreferrals@mainegeneral.org

Hospitalizations:

Hospital Name and Dates ____

Incarcerations:

Facility Name and Dates ____

Current Legal Issues? Y ☐ N ☐ ____

Probation/Pretrial/Drug Court

***********THIS SECTION IS FOR MGCC BHS ADMINISTRATIVE STAFF USE ONLY************

ACT Admission Date (Tier): ____________________________________

Counseling Intake Appointment Date: ____________________________

Women's Residential Screening Date: ____________________________

Date Reviewed with Clinical Team: ________________________________

Disposition:

Meets Criteria ☐ Meets Criteria, add to waitlist ☐ Does Not Meet Criteria ☐

Created: January 21, 2021