MaineGeneral Community Care

Patient Label

MaineGeneral Community Care Outpatient Counseling Referral Form

Date of Referral:_____ **Office**: ☐ Augusta ☐ Waterville ☐ Either

Client Name:_____ **Preferred Name:**_____

Date of Birth:_____ **Social Security Number:**_____

Birth Gender: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ TG Male ☐ TG Female ☐ Other

Mailing Address:_____

Physical Address (if different):_____

Primary Phone Number:_____ **Secondary Phone Number:**_____

Best Way to Contact Client: _____

Class Member: ☐ Yes ☐ No **Ethnic Origin:**_____ **Marital Status:**_____

Living Arrangements: ☐ Unhoused ☐ Alone ☐ Lives with family ☐ Homeless shelter ☐ PNMI
Other_____

Income $_____ **Family Size:**_____ ☐ IV Drug User ☐ Pregnant

Guardian/Emergency Contact: _____
Relationship to client_____ Phone_____
Address _____

Any Special Accommodations:_____

Primary Insurance:_____ **ID #**_____ **Group #**_____
Secondary Insurance:_____ **ID#**_____ **Group #**_____

Referral Source: _____ **Phone #** _____

Address:_____ **Fax #**_____

Reason for Referral (presenting problem, clinical rationale, diagnosis):

☐ **Mental Health** ☐ **Substance Use Disorder** ☐**Co-occurring**

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_____ _____
Staff Signature Date/Time