Behavioral Health Resources of Maine
REFERRAL FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY
Incomplete forms may delay processing.

Date ____/____/____

Referent Name _____ Email _____

Referral Organization _____ Phone _____

Service(s) Requested: ___MH assess ___Medication management ___MH Counselling

___SA assessment ___IOP ___Suboxone ___SA Counselling Other _____

CLIENT INFORMATION

First Name _____MI ____ Last Name _____

Prefered Name _____ SEX _____ DOB ____/____/____ SS#_____

Cell phone _____ Alternate Phone _____ Email _____

Address _____ Apt _____

City _____ State _____ Zip _____

PRIMARY INSURANCE **For Maine Care eligible clients only complete the Policy #1*

Insurer _____ Phone # _____

Policy # _____ Group # _____

Policyholder Name _____ DOB ____/____/____

SS# _____ Relationship to Insured _____

Policyholder Employer _____

Policyholder Address _____

Policyholder City/State/Zip _____-_____

IF MAINECARE CLIENT, HAS THIS CLIENT BEEN DISCHARGED FROM THEIR PREVIOUS PROVIDERS?
NO_____ YES_____

PLEASE FAX ALL PAGES OF THIS REFERRAL FORM TO:
BHRM Administrative Support @ 207-747-5958
BHRM referral form rev. 11/4/2017

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SECONDARY INSURANCE *For Maine Care eligible clients only complete the Policy #1

Insurer _____ Phone # _____

Policy #: _____ Group _____

Policyholder Name: _____ DOB ____/____/____

SS # _____ Relationship to Insured _____

Policyholder Employer _____

Policyholder Address _____

Policyholder City / State / Zip _____

IF MEDICARE INSURED, DOES CLIENT HAVE PART D PRESCRIPTION BENEFITS?

Insurer _____ Phone _____

Policy # _____ Group # _____

Does this client have a legal guardian? NO_____ YES_____ *If yes, please provide:*

Name _____ Relationship _____ Phone _____

Is this a Mainecare insured client in a PMNI facility? NO_____ YES_____ *If yes, what is the billing appendix if known* _____

Is this client an AMHI class member? NO_____ YES_____

Has this client been hospitalized for any reason within the past year? NO_____ YES_____ *If yes, please give a brief description* _____

Has this client used Crisis Services in the past year? NO_____ YES_____ *If yes, please give a brief description*

_____

_____

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Have psychiatric medications been prescribed to this client in the past 2 years? NO_____ YES_____ *If yes, please list medications*: _____

Who is the prescriber and are they still seeing that provider? _____

_____

Please list any non-psych medications currently prescribed _____

_____

Is this client having any thoughts of harming themselves? NO_____ YES_____ *If yes, please give a brief description* _____

_____

_____

QUESTIONS TO BE ANSWERED FOR SUBSTANCE ABUSE REFERRALS ONLY

Current or last use of any substances: Please list substance type and last use:

_____

_____

Is client currently or in the past being prescribed Suboxone or Subutex? NO_____ YES_____ *If yes, please list where and when* _____

_____

_____

Has the client participated in Intensive Outpatient Treatment? NO_____ YES_____ *If yes, please list where and when* _____

_____

_____

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Clinical information/presenting problems

History:

Current providers:

___ Crisis team _____

___ Case manager _____

___ Therapist _____

___ PCP _____

___ Other _____

Barriers to treatment (e.g. cost, transportation, language - need interpreter):

Current status (e.g. hospitalized, crisis unit, incarceration, residential program):