Volunteers of America
NORTHERN NEW ENGLAND

Integrated Outpatient Services – Referral Form

Date of Referral: ____/____/20___ Referred By:_____

Phone No: _____

Client Information – Fill Out All Information Completely

Name: _____DOB: ____/____/_____ SS# _____-____-_____

Address: _____

Telephone: Home:_____ Work:_____ Cell: _____

Ok, to leave message? ☐ **Yes /** ☐ **No**

Parent/Guardian Name: _____

Parent/Guardian Address (if different): _____

Parent/Guardian Telephone (if different): Home:_____ Work:_____Cell: _____

☐ **Male** ☐ **Female,** Marital Status (circle one): **Single Married Separated Divorced**

Employed: ☐YES ☐ NO Occupation: _____ **Student?:** ☐ YES ☐ NO

Current school and educational level or highest grade achieved: _____

Current medications, (including over-the –counter) and known drug reactions: _____

_____ **Known allergies: _____**

Who prescribed medication? _____

Name, telephone and address of next of Kin: _____

_____

Statement of Concern/Problem:

Reason for seeking service: _____

_____

_____

_____

Desired outcome(s) of service: _____

_____

_____

_____

Use of substances: ☐ Yes ☐ No If yes, what: _____

How often: _____

Please complete all forms in black ink.

CONFIDENTIAL

Previous mental health services? ☐ Yes ☐ N When?_____

Where? _____

Present or past safety concerns (i.e. suicidal, homicidal..): ☐ Yes ☐ No

If yes, describe: _____

_____

Primary care doctor: _____ Phone: _____

******9-1-1 or 774-HELP (888-568-112)******

Insurance (Please get complete insurance information)

☐**MaineCare** ☐**Private Insurance** ☐**Medicare** ☐**Secondary Insurance** ☐**Self-Pay** ☐**Other____**

Primary Insurance: _____ Policy Holders SS#: _____-____-_____

Policy Number: _____Group Number: _____

Name of Policy Holder: _____

Client's Relationship to Policy Holder (circle one): SELF SPOUSE CHILD OTHER

Prior authorization obtained (if required): ☐Yes ☐No

Secondary Insurance: _____ Policy Holders SS#: _____-____-_____

Policy Number: _____Group Number: _____

Name of Policy Holder: _____

Client's Relationship to Policy Holder (circle one): **SELF SPOUSE CHILD OTHER**

Prior authorization obtained (if required): ☐Yes ☐No

Additional Information

Additional Notes:_____

_____

_____

Days/Times Preferred: _____

Meets criteria for admission: ☐ Yes ☐ No

If NO, was referral offered: ☐Yes ☐ No **If YES, complete intake log.**

Referral taken by: _____

Logged on Intake and Referral Form: ☐Yes ☐ No Logged by: _____