MAINE BEHAVIORAL HEALTH ORGANIZATION
est. 2011

MBHO Referral Form

Referral Type: ☐ Children's Case Management ☐ Adult Case Management
☐ Counseling ☐ Med Management ☐ School-Based Counseling ☐ Substance Abuse
☐ All Services-Adult ☐ All Services-Children's

Client Name:	DOB:	SS #:
Class Member: ☐Yes ☐No	Grant Fund Eligible	☐Yes ☐No
Insurance:	Policy Number:	
Physical Address:		
Mailing Address:		
Mental Health Dx: Axis I:		
Diagnosed by :	Date:	
Guardian Name:	Guardian Phone #:	
Interpreter needed? ☐Yes ☐No		
Home Phone Number:	Cell Phone:	
Permission to leave a message? ☐Yes ☐No		
Referral Source Name/Organization:		
Referral Source Address:		
Referral Source Contact Phone:	Cell:	Fax:
Referral Source email address:		
Reason for Referral:		
Dangerous variables (***please include recent crisis/hospitalizations, incarcerations, violent or aggressive behavior, contagious medical conditions, criminal history, risk to self or others or other pertinent safety issues***):		
Mental Health Provider Names:		
Other Information (***best time to contact, client information needed before intake, living conditions, etc.)***		
Signature of person making referral:		Date:
Office Use Only		
Date Referral Received:	Time Received:	
Insurance Verification Information:	Date Verified:	
Verified by:		

Send to: 30 Leavitt St. Skowhegan, ME. 04976
Phone: 1-888-922-4736 Fax: 844-331-2315

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