

**Evergreen Behavioral Services**  
**Referral Form**  
**Intake Number: 779-2398 Fax Number: 779-2143**

Date: \_\_\_\_\_ Referral Name: \_\_\_\_\_ Referral Tel: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female  Other identified: \_\_\_\_\_

SS # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Tel #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Emergency contact name/relationship/tel #: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Insurance Information:**  Mainecare/Medicaid Mainecare/Medicaid #: \_\_\_\_\_  
 Commercial Ins: Policy #: \_\_\_\_\_  
 Medicare  Self Pay

**Services Requested:**  MH Therapy  Substance Abuse Counseling  WRAP  IOP  
 DEEP  CIS/BHH  TCM/BHH  DBT

**Current Issues:**  Anger  Anxiety  Depression  Family  
 Marital  Self-Injury  Substance  Other: \_\_\_\_\_

**List all current services with other Agencies:**

\_\_\_\_\_  
\_\_\_\_\_

**AMHI Class Member:**  Yes  No **Veteran:**  Yes  No

**Physical Accommodations needed:**  N  Y \_\_\_\_\_ **Need for interpreter Services**  N  Y

*For Minors:*

Parent/Guardian Name: \_\_\_\_\_ Tel# \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Tel # \_\_\_\_\_

Parent Status:  Married  Separated  Divorced  Widowed  Single  Other

Legal documentation of custody/guardianship:  On file  Requested on \_\_\_\_\_

DHHS Involvement:  Yes  No Case ID: \_\_\_\_\_

DHHS Case Worker Name: \_\_\_\_\_ Tel: \_\_\_\_\_