Spring Harbor Hospital
MaineHealth
A division of Maine Behavioral Healthcare

REFERRAL FORM

CLIENT NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

BIRTH DATE: _____ SOCIAL SECURITY #_____

INSURANCE: _____

OUTPATIENT THERAPIST: _____

OUTPATIENT PSYCHIATRIST: _____

REFERRAL FROM: _____

Address: _____

Phone: _____

REASON FOR REFERRAL: _____

_____

_____

_____

REQUESTED TREATMENT GOALS: _____

_____

_____

_____

_____

_____

_____

TELEPHONE: 207-283-7660 FAX: 207-283-7664

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CLIENT NAME: _____

DIAGNOSIS: AXIS I: _____

AXIS II: _____

BRIEF PSYCHIATRIC HISTORY (include pertinent medical information and hospitalizations):

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATION HISTORY & CURRENT MEDICATIONS: _____

_____

_____

_____

HISTORY OF SUBSTANCE ABUSE: _____

_____

_____

FAMILY HISTORY: _____

_____

_____

_____

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