REFERRAL FORM

Outpatient Behavioral Health Services
Partial Hospitalization for Psychiatrically Ill Adults

PHONE: 207-283-7660 **FAX: 207-283-7664**

Client Name: ____

Address: ____

Phone Number: ____

Birth Date: ____________________ Social Security #: ____________________________

Insurance: ____

Outpatient Therapist: ____

Outpatient Psychiatrist: ____

Referral from: ____

Address: ____

Phone: ____

Reason for Referral: ____

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Requested Treatment Goals: ____

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Referral Form

Client Name: ____

Diagnosis: Axis I: ____

Axis II: ____

Brief Psychiatric History (include pertinent medical information and hospitalizations):

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Medication History & Current Medications: ______________________________

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History of Substance Abuse: ______________________________________

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Family History: ____

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