Dawnland Associates Referral Form

**Please complete this form in its entirety*
Incomplete forms may delay processing

Date _____

Referent Name _____ Email _____

Referral Organization _____ Phone _____

Services Requested: ___ Medication Management ___ SA Assessment/Counseling

Client Information

First Name _____ MI ____ Last name _____

Preferred Name _____ Sex ___ DOB _____SS# _____

Cell Phone _____ Alt Phone _____

Email _____

Address _____

City _____ State _____ Zip _____

Primary Insurance **For MaineCare eligible clients only complete Policy #1*

Insurer _____Phone # _____

Policy/Member ID# _____Group # _____

Policyholder Name _____DOB _____

SS# _____Relationship to Insured _____

Policyholder Employer _____

Policyholder Address _____

Policyholder City/State/Zip

_____

IF MAINECARE CLIENT, HAS THIS CLIENT BEEN DISCHARGED FROM THEIR PREVIOUS PROVIDERS?

No ____ Yes ____

Please fax all pages of this referral form to: Dawnland Associates @ 207-221-1710

Secondary Insurance ***For MaineCare eligible clients only complete Policy #1***

Insurer _____Phone # _____

Policy/Member ID# _____Group # _____

Policyholder Name _____DOB _____

SS# _____Relationship to Insured _____

Policyholder Employer _____

Policyholder Address _____

Policyholder City/State/Zip

_____

IF MEDICARE INSURED, DOES CLIENT HAVE PART D PRESCRIPTION BENEFITS?

Insurer _____ Phone # _____

Policy # _____ Group # _____

These next answers are required for us to consider your referral

Does this client have a legal guardian? ___ No ___ Yes *If yes, please provide:*

Name _____ Relationship _____ Phone _____

Is this a MaineCare insured client in a PMNI facility? ___ No ___ Yes *If yes:*

Billing appendix? _____

Is this client an AMHI class member? ___ No ___ Yes

Has this client been hospitalized for any reason within the past year? ___ No ___ Yes

If yes, please give a brief description:

_____

_____

Has this client used crisis services in the past year? ___ No ___ Yes

If yes, please give a brief description:

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Have psychiatric medications been prescribed to this client in the past 2 years? ___ No ___ Yes If yes, please list medications: _____

_____

Who is the prescriber and are they still seeing that provider? _____

_____

Please list any non-psych medications currently prescribed: _____

_____

Is this client having any thoughts of harming themselves? ___ No ___ Yes

If yes, please give a brief description: _____

_____

Current or last use of any substances? _____

_____

Is client currently or in the past being prescribed Suboxone or Subutex? ___ No ___ Yes

If yes, please list where and when _____

Has the client participated in Intensive Outpatient Treatment (IOP)? ___ No ___ Yes

If yes, please list where and when _____

_____

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Current providers:

___ Crisis Team _____

___ Case Manager _____

___ Therapist _____

___ PCP _____

___ Other _____

Barriers to Treatment (cost, technology, language)?:

Current status (e.g. hospitalized, residential program, incarcerated)?:

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