SEQUEL CARE
Community Based Services of Maine

Referral Form

Print this form and fax it to us at 338-8962

Referring Agency _____ Phone _____ Date _____

Name of Person Completing Referral _____ Email _____

How did you hear about us? _____

CLIENT INFORMATION

Client Name _____ Date of Birth _____ Gender: M ☐ F ☐ Trans ☐

Is the client an Augusta Mental Health Institute (AMHI) Consent Decree class member? Y ☐ N ☐

Address _____ Phone _____

Client's Mental Health Diagnosis with F-code if known _____ Already our client? Y ☐ N ☐ Unknown ☐

Please provide a signed copy of diagnosis that has been completed within the past 12 months for BHH and DLS services

If applicable, Parent or Guardian name _____ Phone number _____

Parent Address _____

INSURANCE INFORMATION

MaineCare ID # _____ Other Insurance Name _____

Group Number _____ Insurance Phone # *(on back of card)* _____

Member ID Number _____ Subscriber Name if other than client _____

Subscriber Date of Birth _____ Subscriber Address _____

REQUESTED SERVICES

Counseling

- ☐ Substance Use Disorder Therapy
- ☐ Outpatient Therapy
- ☐ School Based Outpatient Therapy
- ☐ Medication Assisted Treatment (Opioid Health Home (MAT)

Assessment

- ☐ Diagnostic
- ☐ Vineland *(for children)*

Other Programs

- ☐ Medication Management
- ☐ Adult Residential Housing (Section 21)
- ☐ ABA Behavioral Consultation
- ☐ Adult Daily Living Support (Section 17)
- ☐ Case Management (BHH)
- ☐ Day Treatment (Section 65 School Based)
- ☐ Licensed Home Health
- ☐ Personal Support Services

Primary reason for referral / additional info