Adult Services Referral Data Sheet

Date: ______________________

Referral Source: ____ **Taken by:** ______________________________________

Client's Name: ____

Date of Birth: ____ **Gender:** ☐ Male ☐ Female

Address: ____

____

City: ____ **State:** ____________________ **Zip:** ______________

Phone: ____ **MaineCare #:** __________________________________

SS#: ____ **SSI:** ☐ Yes ☐ No **SSDI:** ☐ Yes ☐ No

Emergency Contact: __________________________________ **Emergency Phone:** ____________________________

Employment Status: __________________________________ **Marital Status:** ______________________________

Psychiatrist: ____ **Phone:** ____

Physician: ____ **Phone:** ____

Class Member: ☐ Yes ☐ No ______________________ **At risk of hospital admission?** ☐ Yes ☐ No

History of Hospitalizations: ____

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CRISIS USE

Current Information (within the past year)

Dx: Primary: ____ Secondary: ____________________________________

Axis I: ____ Axis II: ____

Co-occurring Medical Conditions: ____

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Current Legal Concerns: ____

Current Providers: ____

Safety Issues: ____

Allergies: ____

Self-identified Case Management Needs: ____

Meets Admitting Criteria? ☐ Yes ☐ No

Must have the following: ☐ 1. MaineCare ☐ 2. Current MH Dx (within last year)

Please fax completed form to: Catholic Charities Maine Mental Health Services at **(207) 453-4371, ATTN: INTAKE**

10/24/13