TRI-COUNTY MENTAL HEALTH SERVICES

REFERRAL

Referral Line for all Locations: **1-888-304-HOPE (4673)**
TTY: **1-888-568-1112**
STATEWIDE CRISIS SERVICES: **1-888-568-1112**

Fax Numbers for Each Location
Lewiston: 783-4660 **Farmington:** 778-3558
Bridgton: 647-5620 **Oxford:** 743-7913
Rumford: 369-0227 **Windham:** 892-5317

IN ORDER TO PROCESS YOUR REFERRAL IN A TIMELY MANNER PLEASE COMPLETE ALL FIELDS.

Section One

CONSUMER IDENTIFYING INFORMATION:

Last Name:_____ First Name: _____ Middle Initial: _____
D.O.B. _____ Social Security #: _____
Contact number: _____ (Acceptable for TCMHS to call this contact number): ◯ Yes ◯ No
Mailing Address: _____
Street/Apt #: _____
City/Town:_____ State: _____ Zip Code:_____

Section Two

REFERRAL RESOURCE INFORMATION
Referred by: _____ Organization: _____
Contact Phone Number:_____ext._____

Do you have a family member or household member who is currently employed with TCMHS?
◯ Yes ◯ No

Section Three

REASON FOR REFERRAL:

RISK FACTORS:
Are you having thoughts of hurting yourself or somebody else at this time?
◯ Yes ◯ No
State Disposition below:

Are you a Class Member? (Hospitalized in a Hospital such as AMHI/Riverview or Pineland
◯ Yes , Check Below ◯ No ◯ Information not obtained

Are you a veteran or have you ever served in the military? ◯ Yes ◯ No

Are you an immediate family member of an individual(s) in the military and/or a veteran? ◯ Yes ◯ No

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Section Four

INSURANCE/PAYSOURCE INFORMATION

Policyholders Name:_____ D.O.B. _____
Insurance Company:_____ Policyholders SS#: _____
Policy ID #:_____ Relationship to the Consumer:_____
Policy Group #:_____

Maine Care #:_____ Medicare#:_____
Self Pay_____ Potential Grant _____

Section Five

PARENTAL RIGHTS/GUARDIANSHIP:

Name of birth parent # 1: _____
Address: _____
Phone number: _____

Name of birth parent # 2: _____
Address: _____
Phone number:_____

Birth parents are: ◯ Married/residing together ◯ Divorced/separated ◯ Unknown

If guardianship is held by someone other than the birth parent (OR) the person you are referring is an adult with a guardian please include name and contact information of guardian: _____
_____

Section Six

REQUESTED SERVICES

Adult Program:_____ Children's Program: _____
Substance Abuse Programs: _____Off-Site Location Requested:_____

If Interpreter is needed complete below:
Communication Method:_____ Primary Language:_____