**Cornerstone Behavioral Healthcare**

**Script for Referrals**

Bangor Phone: 992-0410/ Fax: 992-0414

Waterville Phone: 680-2065/ Fax: 680-2068

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| **Services being requested** | |
| ☐Individual/Family Therapy | ☐Co-occurring/SU |
| ☐Group | ☐Suboxone/ MAT |
| ☐BHHO Case Management | ☐OHH |

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| **Demographics** | | | |
| Client’s Name: | | | DOB: |
| Current Mailing/Street Address: | | | |
| City: | State: | Zip Code: | |
| Phone: | | | |
| Email: | | | |
| If client is a child, parent name(s): | | | |
| Gender: ☐Male ☐Female ☐Transgender ☐Non binary ☐Other | | | |

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| **Insurance(s)**  **It is the client/guardian’s responsibility to pay all out of pocket amounts at the time of service** | |
| Primary Insurance: |  |
| Name of Guarantor: |  |
| Policy Number: |  |
| Group Number: |  |
| Telephone Number: |  |
| Secondary Insurance: |  |
| Name of Guarantor: |  |
| Policy Number: |  |
| Group Number: |  |
| Telephone Number: |  |

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| **Reason for Services** | |
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| Does the client have an emergency contact?  If yes, who?  Relationship: Phone: | ☐Yes ☐No |
| Does the client have a guardian? If yes, who? | ☐Yes ☐No |
| Does the client have parent contact information? | ☐Yes ☐No |
| Are the client’s parents divorced or separated? | ☐Yes ☐No |
| 1. **If applicable, we will need a copy of the divorce or custody agreement at the time of the initial appointment.** | |
| 1. **Without said agreement, both parties will have the right to information regarding the client.** | |
| 1. **Cornerstone does not get involved in custody disagreements regarding finances.** | |
| 1. **Probation paperwork is required.** | |
| If the client is a child, where is the child currently residing? | |
| ***Parent/ guardian must be present at first appointment.*** | |

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| On a scale of 1-10, how would the client rank their mental health in the last 30 days? (1 being best, 10 being worst) |  |
| Does the client currently have or have they ever had thoughts of suicide? | ☐Yes ☐No |
| Has the client been hospitalized in the past 30 days for mental health or substance use? | ☐Yes ☐No |
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| Does the client have a mental health diagnosis? | ☐Yes ☐No |
| What is that diagnosis (if known): |  |
| Diagnosed by whom (if known): | |
| Is the client an AMHI Consent Decree Member? | ☐Yes ☐No |

**Preferred Method of Delivery**

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| In Office | ☐Yes ☐No |
| Telehealth (computer audio/visual) | ☐Yes ☐No |
| Telephonic (telephone only) | ☐Yes ☐No |

\**insurance restrictions may apply*

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| Does the client require special accommodations? | ☐Yes ☐No |
| If yes, please describe: | |
|  | |
| **Crisis and Counseling #1-888-568-1112 (if needed)** | |