**Cornerstone Behavioral Healthcare**

**Script for Referrals**

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

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

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| --- | --- | --- | --- |
| **Referral Date:** |  | **Completed By:** |  |
| Is the client enrolled in services with another provider at this time? [ ] Yes [ ] No |
| **Requested Services** |
| ☐Individual/Family Therapy Services | ☐Suboxone/ MOUD Services  |
| ☐Group Therapy Services | ☐SUD Counseling Services |
| ☐Case Management Services | [ ] Psych Testing Services |
| [ ] Co-Occurring Services | [ ] Other: |  |
| [ ] Medication Management Services |  |  |

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| **Demographics** |
| Client’s Name: |  | DOB: |  |
| Current Mailing/Street Address: |  |
| City: |  | State: |  | Zip Code:  |  |
| Phone: |  | Email: |  |
| Gender: ☐Male ☐Female ☐Transgender ☐Non binary ☐Other |
| (If applicable) Guardian/Legal Representative: |  |
| (If applicable) Are parents separated or divorced? | ☐Yes (we’ll need a copy of agreement) ☐No |
| (If applicable) Emergency Contact Name: |  |
| Relationship: |  | Phone #: |  |
| **Insurance(s)**-It is the client/guardian’s responsibility to pay all out of pocket amounts at the time of service |
| Primary Ins: |  | Secondary Ins: |  |
| Guarantor: |  | Guarantor: |  |
| Policy #: |  | Policy #: |  |
| Group #: |  | Group #: |  |
| Telephone #: |  | Telephone #: |  |

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| **Reason for Services** |
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| **Service Questions** |
| Has the client recently had thoughts of harming self or others?  | ☐Yes ☐No |
| Has the client been hospitalized in the past 30 days for mental health or substance use? | ☐Yes ☐No |
| If the client is seeking medication management or MOUD services, are they currently on any type of medication? | [ ] Yes [ ] No |
| Is client pregnant? | [ ] Yes [ ] No |
| Is the client recently released from jail? | [ ] Yes [ ] No (probation paperwork on intake)  |
| Does client have a history of overdose? | [ ] Yes [ ] No |
| If yes, last occurrence: |  | Is client currently in withdrawal: [ ] Yes [ ] No  |
| **Guardian/Legal Representative must be present at first appointment.** |
| **Referral Follow-up Date:** |  | **Completed By:** |  |
| Client’s Name: |  | DOB: |  |
| **Follow-up/Admission Questions** |
| If the client indicated on page one that they had another provider: |
| Provider Name: |  | Service Provided: |  |
| If the client indicated on page one that their parents were separated or divorced: |
| Current residence: |  | With: |  |
| 1. If applicable, we will need a copy of the divorce or custody agreement at the time of the initial appointment.
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| 1. Without said agreement, both parties will have the right to information regarding the client.
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| 1. Cornerstone does not get involved in custody disagreements regarding finances.
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| 1. Probation paperwork is required.
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| **How would they like to receive services:** |
| In Office | ☐Yes ☐No |
| Telehealth (computer audio/visual) | ☐Yes ☐No |
| Telephonic (telephone only) | ☐Yes ☐No |
| \**Insurance restrictions may apply* |
| **Special Accommodations:** |
| Does the client require special accommodations? | ☐Yes ☐No |
|  |  |
| If yes, please describe: |
| **Is there anything else the client would like Cornerstone to know about them?** |
| **Diagnosis:** |
| Does the client have a mental health diagnosis? | ☐Yes ☐No |
| What is that diagnosis (if known): |  |
| Diagnosed by whom & when (if known): |
| **How was the client referred to our agency:** |
| [ ] Friend [ ] Another client [ ] Another agency [ ] Family [ ] Medical referral  |
| [ ] Other (please explain): |
| **Other resources: Crisis and Counseling #1-888-568-1112/Careline #1-844-844-2622** |