**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** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **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. | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | |
| **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** | | | | | | | | | | | | | | |