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:** 743-6959
Rumford: 369-0227

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: _____ Office address: _____
Contact Phone Number:_____ext._____

Does the person being referred have a family member or household member who is currently employed with TCMHS?
Yes No Unknown

Section Three

REASON FOR REFERRAL:

RISK FACTORS:
Is the person you are referring having thoughts of hurting him/herself or somebody else at this time?
Yes No
State Disposition below:

Is the person being referred a Class Member? Yes No Unknown

Is the person being referred a veteran or have you ever served in the military?
Yes No Unknown

Is the person being referred an immediate family member of an individual(s) in the military and/or a veteran? Yes No Unknown

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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
Outpatient Counseling:_____ Substance Use Disorder Counseling: _____
Behavioral Health Home/Case management: _____ Other:_____ (see complete list of services below)

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

Tri-County Mental Health Services
Services Available

Adult Outpatient Services
Behavioral Health Homes (BHH)
Child and Family Outpatient Services
Assertive Community Treatment (ACT)
Eye Movement Desensitization Reprocessing (EMDR)
Integrated Primary Care (IPC)
Maine Mother's Network
Multi-Systemic Therapy (MST)
Multi-Systemic Therapy – Problem Sexual Behaviors (MST-PSB)
Substance Use Disorder Services