**Healing Tide Therapy**
**25 Middle Street**
**Portland, Maine 04101**

# PROFESSIONAL REFERRAL

☐ **Outpatient Therapy**

Date _____

Client Name _____ Date of Birth _____
SS# _____
Address _____ Phone _____
_____ MaineCare ☐ Yes ☐ No
_____ MaineCare # _____
Insurance Company & Information _____

Marital Status _____ Employment Status _____
Veteran Status _____ Income _____
Male/Female/TG _____ Income Source _____
Class Member: ☐ Yes ☐ No Primary Language _____
Citizenship ☐ Yes ☐ No Education Level _____

Guardian: ☐ Yes ☐ No Guardian Name: Phone:
Rep. Payee: Phone:
PCP: Agency: Phone:
Psychiatrist: Agency: Phone:
Therapist: Agency: Phone:
Referred by: Agency: Phone:

Reason for Referral (include current situation and why this person needs this services):

Hospitalization History (include dates):

Medical Conditions/Allergies:

Substance Abuse History: ☐ Yes ☐ No Currently Using: ☐ Yes ☐ No
If yes, describe:

Current Medications:

History of harm to self/others (include dates):

Describe any legal involvement (include probation):

What strengths has the individual demonstrated?

Are there any current mental health or substance use disorder diagnoses? ☐ Yes ☐ No

| | DSM-V Diagnosis & Modifier(s) | **Diagnostic Code:** *ICD-10 Codes only* |
|---|---|---|
| Primary Diagnosis: | | |
| Secondary Diagnosis: | | |
| | | |