GRAHAM
BEHAVIORAL SERVICES INC.

SECTION 17 REFERRAL FORM

PROGRAM REFERRED TO:
Community Integration _____
Skills Development _____
Daily Living Skills _____

DATE OF REFERRAL: _____

GBS _____

CLIENT INFORMATION:

Client's Name:		Date of Birth:		Gender:	
Address:		SS #:			
City:		MaineCare #:			
State: **Maine**	Zip:		County:		
Primary Telephone:	**207-**	Class Member:	☐ Yes ☐ No		
Other Telephone:	**207-**	AMHI Consent Decree:	☐ Yes ☐ No		

REFERRAL INFORMATION:

Person making the referral:		Guardian's Name:	
Relationship to Client:		Address:	
Agency:		City:	
Address:		State:	**Maine**
City:		Zip:	
State/Zip:	**Maine**	Telephone:	**207-**
Telephone:	**207-**	Other Telephone:	**207-**

Primary Diagnosis:		DX Code:	
By Whom:		Date:	
Provider Phone #			

Risk Factors (What is causing the risk?)

☐ **Homelessness:** _____

☐ **Incarceration:** _____

☐ **Need for a Higher Level of Care:**_____

☐ **Psychiatric Hospitalization:**_____

History of…. (dates, durations, and reasons)

☐ **Homelessness (dates, durations, and reasons):**_____

☐ **Incarceration (dates, durations, reasons)**_____

☐**Arrest (Dates, reason)**_____

☐ **History of Assisted Living Residences (dates, durations, and reasons):**_____

☐ **Psychiatric Hospitalization (Where, when, duration, reason, voluntary/involuntary):**_____

Service needed for Mental Health Needs: *(Narrative list- mental health symptoms, housing needs, Why is CIS, Skills or DLS services needed)*

Previous Mental Health Services?

Other Current Mental Health Services?

Current Waitlists?

Supports & Phone numbers; Providers and natural supports involved in treatment:
Hospitalizations/Medical History/Conditions/Concerns/Allergies

Additional information: *Medical Concerns and/or limitations (Include accommodations, preferences, and safety if needed)*

Please provide the following with referral:

□ Release of information
□ ISP/Treatment Plan
□ Crisis Plan
□ Copy of current Diagnosis
□ Most recent diagnosing provider's progress note
□ Service Agreement Form – Class Members Only
□ LOCUS
□ ANSA
□ Comprehensive Assessment

Referral completed by:

Please fax this form and the attached documents to us at 207-626-0004