REFERRAL FORM

Hand of Mercy Health Care

Main Office: 1087 Forest Ave
Portland, ME 04103
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www. homhealthcare.org

Referral Form		**Today's Date:**	
Patient's Name:	**AMHI Consent Decree? ☐ Yes ☐ No**	**DOB:**	
Gender: ☐ M ☐ F ☐ Other:	**Race:**	**Telephone:**	
Health Insurance Company:	**Health Insurance ID:**		
Address:	**City:**	**State:**	**Zip Code:**
Language:	**Interpreter Need? ☐ Yes ☐ No**	**Provider Requested:**	
Substance Abuse? ☐ Yes ☐ No	**Is client in crisis? ☐ Yes ☐ No**	**Safety Concerns? ☐ Yes ☐ No**	
Marital Status:	**Hispanic/Latino ☐ Yes ☐ No**		
Service Requested			
☐ Case Management	**☐ Counseling/Outpatient Therapy**		
Any Physical Disability? Yes ☐ No ☐ If yes what's the disability:			
Any Dental Needs? Yes ☐ No ☐ If yes, explain:			
Any Hospitalization? ☐ Yes ☐ No	**Date:**		
List of Symptoms:			
Mental Health Diagnoses:			
Source of Diagnoses:			
At risk of being jailed? Yes ☐ No ☐ At risk of hospitalization? Yes ☐ No ☐ At risk of homelessness? Yes ☐ No☐			
Emergency Contact Name:	**Relationship:**	**Phone:**	
Referred by:	**Date:**		
Organization Name:	**Email:**	**Phone:**	
Signature:	**Name:**	**Date:**	
To be Completed by Hand of Mercy Health Care			
Assigned Case Manager:	**Date:**		
Assigned Counselor:	**Date:**		