GRAHAM
BEHAVIORAL SERVICES INC.

REFERRAL FORM

PROGRAM REFERRED TO:
Section 17 – 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 #			

Description of Needs/Goals Desired: *(Narrative-list - mental health symptoms, housing needs, why is support needed)*
Supports: *(Current natural supports and providers involved in recovery telephone #.)*
Medical History/Conditions/Concerns/Allergies.; *(Past providers, hospitalizations, treatments)*
Additional Comments: *(Include accommodations, preferences, and safety if needed)*

Referral completed by: _____

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

- ISP/Treatment Plan
- Crisis Plan
- Diagnosis
- LOCUS
- Comprehensive Assessment
- Service Agreement Form – Class Members Only