clarvida

CARE COORDINATION REFERRAL

SERVICE REQUESTED:												
	Children's BHH		Adult CI		Adult BHH		TCM Mental Health (UC)		TCM DD/Autism/ID (UD)		TCM Medical CC Only (UB)	

REFERENT CONTACT INFORMATION:				**Date Sent (by referent):**	
Name:		Relation to Client:		Agency:	
Office Address:					
Phone:		Ext:		Email:	

DEMOGRAPHICS OF CLIENT: **(client's name spelled as it appears on MaineCare card)**													
First Name:			MI:		Last Name:								
Gender:		Male		Female		Transgender		M/F		F/M			
DOB:		SSN:		MaineCare #:		Race (optional):		Class Member:					

Reason for Referral:				
Is the family open to telehealth services?		Yes		No
Is this client already open in a Health Home or Community Care Team service?		Yes		No

CLIENT'S CURRENT RESIDENCE: **(legal address where client will receive services)**					
Client's full address (street, city, state, zip):					
Cell:		Phone:		Email:	

LEGAL GUARDIANS:			**N/A**		
Name:		Cell:		Phone:	
Full address:					

GUARDIAN(S) CUSTODY:		Married		Sole Custody		Own Guardian		Shared		DHHS

SHARED CUSTODY:		N/A		
Name:	Cell:		Phone:	
Full address:				

PRIMARY DIAGNOSIS: **(please submit a Proof of Diagnosis along with this referral form)**					
Current DX (F code):		Date of DX (date last seen by provider):		Source of DX (provider name):	
LOCUS Score:		Date of LOCUS:			LOCUS unknown

PRIMARY LANGUAGE:			
Client's Primary Language:		Caregiver's Primary Language:	
Does this client/family utilize interpreter services?		Yes		No
Name of Interpreter:		Contact #:	