Center for Autism and Developmental Disorders Outpatient Clinic
Maine Behavioral Healthcare

Provider Referral Form

Referral Source Information

Referring Provider ______________________ Agency __________________________

Address ____

Phone #_____________________ Fax # __________________________

Date of Referral _______________ Completed by ______________________

Patient Information

Name_________________________________ DOB_______________ Age_______

Guardian's Name________________________

Guardian's Address____

Phone # _________________________

Primary Language Spoken _________________ Interpreter Needed ◻ Yes ◻ No

Insurance Information

Primary ____________________________________

Secondary ____________________________________

Has this child been diagnosed with Autism Spectrum Disorder or Intellectual Disability, either by you or by another provider? ◻ **Yes** ◻ **No**

Reason for Referral

Presenting Problem - Please check all that apply – (Circle your #1)

◻ Anxiety ◻ Tantrums ◻ Self-Injurious Behavior ◻ Family Issues

◻ Depression ◻ Grief/Loss ◻ Aggression ◻ Regression

◻ Mood Dysregulation ◻ Trauma ◻ Other: ____________________________

Please briefly describe the reason you are referring this patient to our clinic.

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What services do you feel this patient needs?

◻ Individual Therapy for Child/Parent/Sibling (please circle)

◻ Family Therapy

◻ Medication Management (Psychiatry)

◻ Behavioral Treatment (ABA) (*Please include MD order for this service*)

◻ Social Skills Group

◻ Case Management

◻ Other _________________________

Is the family aware of this referral? ◻ Yes ◻ No

May we contact the family? ◻ Yes ◻ No

****Please include your first and last progress notes, a treatment summary (if available), and any neuropsychological testing with this referral. Please note that the patient's guardian will need to complete the Patient Information Packet (available on our website) prior to making an appointment.**

Thank you for your referral!

For questions, please contact Kim Loika-Smith, Program Manager at 661-6703 or kloikasmit@mainebehavioralhealthcare.org