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.

_____
_____
_____
_____

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

Thank you for your referral!
For questions, please contact Kim Loika-Smith, Program Manager at 661-6703 or kloikasmit@mainebehavioralhealthcare.org

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