



EZ Referral and Screening Form

Self-referrals are welcome. Complete what you can. Fax to 207-777-4649.
Questions or help choosing a service? Call 207-333-1080.

Client information

Full name: _____ Referral date: _____

Date of birth: _____ Phone: _____

Email: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Parent or guardian, if applicable: _____ Phone: _____

OK to leave voicemail? ☐ Yes ☐ No OK to email? ☐ Yes ☐ No

OK to text appointment reminders? ☐ Yes ☐ No Best time to reach you: _____

Services requested

Check all that apply. ☐ Not sure which service is the best fit

☐ Individual mental health counseling ☐ Individual substance use counseling

☐ Mental health group ☐ Substance use group ☐ Substance use intensive outpatient / IOP

☐ Medication management / MAT ☐ DEEP evaluations and treatment

Evaluation: ☐ Mental health ☐ Substance use

Location: ☐ Lewiston ☐ Wilton Visit preference: ☐ In person ☐ Telehealth ☐ No preference

Reason for referral

Briefly describe concerns, symptoms or goals.

Other treatment providers or services, if any: _____

Insurance and payment

☐ MaineCare ☐ Private insurance ☐ Self-pay ☐ Unsure

Primary insurance: _____ Member ID: _____

Secondary insurance: _____ Member ID: _____

MaineCare, self-pay and select private plans are accepted. Please call to verify coverage.

Referral source

☐ Self ☐ Parent or guardian ☐ Provider or organization ☐ Other

Name / organization: _____ Phone: _____

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