

Gateway Community Services

124 CANAL STREET
LEWISTON, ME 04240
TEL: 207-536-5999
FAX: 207-536-5998

501 FOREST AVENUE
PORTLAND, ME 04103
TEL: 207-536-1590
FAX: 207-536-1591

12 SHUMAN AVENUE
AUGUSTA, ME 04330
TEL: 207-512-4666
FAX: 207-512-4650

443 MAIN STREET
BIDDEFORD, ME 04005
TEL: 207-536-5903
FAX: 207-573-7458

Referral Form

Client Name: _____ DOB: _____ Gender: _____ Adult or Child

Guardian/Parent(s) For Children only: _____ Telephone: _____

Address: _____ Email: _____

Language: _____ Preferred Interpreter: _____

MaineCare# _____ SS# _____ Class Member: Yes or No

Date of Referral: _____ Referral Source Name/Provider Credentials: _____

Referral Contact: Telephone: _____ Email: _____

Current Diagnosis/Symptoms: _____ Substance Abuse: Yes No

Are you part of an OHH (Opioid Health Home): Yes No

Reasons for Referral (circle all that apply):

Citizenship/Immigration Housing Mental Health Financial Resources Education PCP

Other: _____

Psychiatrically hospitalized in the last two years? Yes No

If yes, where, when & why? _____

Crisis Services Involvement (including trips to the local ED)? Yes No

If yes, where, when, & why? _____

Current Providers If Any: _____

Services Requested (Please Circle Below):

Case Management Counseling BHHO

Client Pimsy # _____ Active Mainecare: _ Yes _____ No _____

***Please send most recent H&P, Assessment, or Clinical Documentation with Referral**

Fax Referrals to 207.536.1591

OFFICE USE ONLY

Referral Received By and Date: _____

Clinical Documents Attached: Yes No