Ocean Way Mental Health Agency

Adult Services Referral Form

Applicant Information: Class Member ___Yes ___No

Name: _____D.O.B._____ Date of Referral: ___/___/_____

Street Address: _____ PO Box: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

MaineCare#: _____ SS#: __ __ __-__ __-__ __ __ __ Phone#:_____

Referred By/Agency: _____ Referral Contact Name:_____

Reason for Referral:_____ Referral Telephone:_____

Services Requested/Needed:

- ☐ Case Management/Community Integration
- ☐ Daily Living Support; Number of hours being sought per week: _____
- ☐ Skills Development Service; Number of hours being sought per week: _____

Briefly describe the services or areas that you expect assistance with: _____

_____

Please Include All of the Following:

- ☐ Signed Authorization to **Release** Information to OWMHA
- ☐ Applicant's **Current ISP** (completed within 90 days) If Applicable
- ☐ Current **LOCUS** Assessment (completed within 1 year) By Physician or Psychiatrist
- ☐ Current **Diagnostic** Information (completed within 1 year) Axis 1 thru 5
- ☐ **Comprehensive Assessment** (completed within 90 days)

Other Items that would be Helpful to Include:

- ☐ Current Medications and Prescribing Physician
- ☐ Legal History/Pending Legal
- ☐ Crisis Plan
- ☐ APS Printout
- ☐ Medical History/Physical (completed within 1 year)

Signature of Referral Source _____ **Date** _____

Send To:

Laurie L. Tardiff, President – Ocean Way Mental Health Agency, 78 Beechwood Street, Thomaston, ME 04861
Phone: 207-354-8184 Fax: 207-354-0487 Email – owmha@hotmail.com

For OWMHA Office Use Only

Referral Received On: ____/____/____ Entered Into APS (PA): ____/____/____ Initial Meeting On: ____/____/____

Extended Stay Completed On: ____/____/____ Staff Assigned On: ____/____/____