Woodfords Family Services
15 Saunders Way, Ste. 900
Westbrook, ME 04092
Phone: (207) 878–9663
Fax: 877-298-4491

Psychiatry Services

Referral

Thank you for referring to Woodfords Family Services' Psychiatry program. We will try to make an appointment for an initial evaluation with a Psychiatry Services professional quickly. Once your evaluation is scheduled, you will receive a packet of intake paperwork in the mail to complete.

In order to expedite the intake process, please fill out the attached Referral Form and include the following documentation, checking off the applicable items:

- ☐ Psychiatry evaluations
- ☐ Psychology test results and evaluations
- ☐ Professional counseling evaluations
- ☐ Discharge summaries from services received within the past year
- ☐ Recent primary care notes
- ☐ Neurology test results and care notes

If you do not have these documents, we will work with you to request them.

Documents from certain service providers are required prior to scheduling the evaluation. Please complete an Authorization to Use and Disclose Confidential Information form for the following providers as applicable:

- ☐ Psychiatry and/or psychology
- ☐ Education/IEP
- ☐ Primary care physician
- ☐ Residential treatment

For all consumers over 18 under guardianship, guardianship documentation is required.

Woodfords has some limits on the type and severity of mental health issues that can be addressed through the Psychiatry program, particularly for adults where we mostly serve individuals with developmental disabilities. We also require that adults have developmental disability case management and/or another formal waiver service involved in the referral and ongoing appointments.

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Referral

If you have any questions, please contact Karen Dehetre at 878-9663, ext. 4170 or email at kdehetre@woodfords.org. Thank you.

Date of Referral: ________________ Referred by: ____________________________________
Agency Name: ____
Address: ______________________________ Telephone: __________________________

A. Client Information:

Client Name: ____ ID# ___________________
DOB: ________________________ Age: ______ Gender: ☐ Male ☐ Female
Is the client his/her own guardian? ☐ Yes ☐ No

Address: ____
Home Phone: ______________ Work Phone: _________________ Other: _______________
Race: _________________________ Primary Language: _______________________________
Need for Interpreter Services: ☐ Yes ☐ No Name and phone number of interpreter used, if any: ____

MaineCare#: _______________________ SS# ____

Current Diagnoses: ____
Allergies: ____

Cultural/Religious/Spiritual Issues: ____

B. Guardian Information if Applicable:

Guardian Name: ____

Address: ____
Home Phone: ______________ Work Phone: _________________ Other: _______________
Primary Language: _______________________________

Need for Interpreter Services: ☐ Yes ☐ No Name and phone number of interpreter used, if any: ____

Name/address of person(s) responsible for medical decisions if different from above: ____

C. Reason for Referral:

____
____
____
____

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Behavioral Concerns:
____
____
____

What do you think is causing the problems? ____________________
____

What do you think is the best treatment for these problems? ____________
____

Have there been any recent changes/losses in the client's life at home/school? ☐ Yes ☐ No

If yes, please describe: ____________________________
____

D. Current Providers/Medical Information:

Psychiatrist: ____________________ Phone: ____________

Pediatrician/Family Physician: ____________ Phone: ____________

Developmental/Behavioral Pediatrician: ________ Phone: ____________

Psychologist: ____________________ Phone: ____________

Neurologist: ____________________ Phone: ____________

Therapist: ____________________ Phone: ____________

List of current medications (dose & time):

1. ________________ 5. ________________
2. ________________ 6. ________________
3. ________________ 7. ________________
4. ________________ 8. ________________

List of past medications and **reasons for discontinuing:**

1. ________________ 3. ________________
2. ________________ 4. ________________

Referral

Any current over the counter or herbal remedies? If yes, please list:

____

____

Pharmacy:______________________Phone#:____

Medical Problems: ____

____

____

Does the client have a history of DRO (drug related organisms) such as MRSA or VRE?
☐ Yes ☐ No
Does the client have a Seizure Disorder? ☐ Yes ☐ No

E: Communication/ADLs:

Is the client verbal? ☐Yes ☐ No
If no, please check, if applicable: ☐PECS ☐Communication Board ☐Sign Language

Recent Speech/Language evaluation? ☐ Yes ☐ No If yes, with whom, when and where?____

Does the client have tactile defensive issues (i.e. food, clothing, etc..)? ☐ Yes ☐ No If yes, please describe:____

Can the client walk without assistance? ☐ Yes ☐ No
If no, what type of help is needed? ☐Wheelchair ☐Gait-belt ☐Walker ☐Other

Does the client utilize any protective equipment? ☐ Yes ☐ No If yes, please describe:

____

Does the client have any feeding issues? ☐ Yes ☐ No If yes, please describe:____

Does the client have a history of choking or aspirating? ☐ Yes ☐ No

F. School Name/Address: ____

School Contact Person and phone number:____

IEP – Date:____________ By: ______________________(Please enclose copy of current IEP)

G. Other Services

Has the client had any involvement with other private or state agencies? ☐ Yes ☐ No
If yes, which agency(ies) and reason for involvement?

____

____

____

Recent psychological testing? ☐ Yes ☐ No If yes, by whom and when?

____

Recent occupational therapy evaluation? ☐ Yes ☐ No If yes, by whom and when?

Is the client on a wait list or scheduled for other evaluation services? ☐ Yes ☐ No
If yes, where?____

Is the client transitioning from or receiving services at another medication provider?
☐ Yes ☐ No If yes, by whom and please describe what has been communicated to the other provider and state whether the other provider is open in APS Healthcare as the psychiatry provider?

____

H. Supporting Documentation (within last two year as applicable)

Current Case Management Service Plan: Agency: ___________________________
Current Section 28 Plan Agency: ___________________________
Current Section 65 Plan Agency:___________________________

I. Evaluations: What type(s) of diagnostic evaluations, date(s) and by whom:

Type: _________________ Date:_________ By:_________________________________

Type: _________________ Date:_________ By:_________________________________

Type: _________________ Date: ________ By: _________________________________

Please answer all questions as applicable and enclose documentation. If you have any questions, please contact Karen Dehetre at 878-9663, ext. 4170 or email at kdehetre@woodfords.org.
Thank you.