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.
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: ____________________________ 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:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
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. ___________________________
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 years 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.