

Location (for PNMI, Crisis Units and Hospitals):	
Referral Date:	
Location at Time of Referral:	___ Hospital ___ Community
Date Worker Assigned:	
*Requesting Agency/Facility	
*Requesting Facility/Agency Name:	
*Requesting Staff First Name:	
*Requesting Staff Last Name:	
*Requesting Staff Phone (W/ Area Code):	
U M/Supervisor Name / Phone:	
* Procedure Request	
*Service Code:	
*Frequency:	
*Start Date:	
*Billing Provider MaineCare ID:	
*Service Length:	
*Units:	
*End Date:	
*Treatment and Service History (required as appropriate)	
<p>Select the tool or tools used to screen for co-occurring mental health and substance use disorders. Next to each selected tool, indicate if there were one or more YES responses. If the AC-OK is used, answer for all 3 domains. If the MHSF III is used, CRAFFT or UNCOPE must also be used.</p> <p> <input type="checkbox"/> This Tool Used: AC-OK MH Issues Domain ___ Yes ___ No <input type="checkbox"/> This Tool Used: AC-OK Trauma Issues Domain ___ Yes ___ No <input type="checkbox"/> This Tool Used: AC-OK Sub Abuse Issues Domain ___ Yes ___ No <input type="checkbox"/> This Tool Used: UNCOPE ___ Yes ___ No <input type="checkbox"/> This Tool Used: CRAFFT ___ Yes ___ No <input type="checkbox"/> This Tool Used: MHSF III ___ Yes ___ No </p>	
Date of assessment for co-occurring disorders:	
Additional Information	
Please provide additional information to support request for services, as needed.	

*Provider Name: _____ *Date: _____

*Provider Signature: _____