OCEANSIDE
COMMUNITY SERVICES, LLP
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Outpatient Therapy Referral Information

***Accepting Maine Care/Medicare/ Anthem and Federal BCBS/Aetna/UHC, as well as other commercial insurance plans where out of network benefit(s) apply (please call to verify)**

Please review the following prior to referral submission:

Submission of this referral form must include applicable current medical (PCP, previous psychiatric records, both outpatient and inpatient) and/or case management records for review prior to referral acceptance.

Our providers do not manage clients with substance use disorders, eating disorders, or those requiring frequent crisis intervention(s) and/or psychiatric hospital admission(s). Please keep the above in mind if the referred client needs a higher level of care than OCS can offer

Please keep the above in mind if the referred client needs a higher level of care than OCS can offer.

Date:	Referred by:		DOA:	OCS #:
Name:	D.O.B.:	Age:	Gender:	Grade:
Primary Language Spoken: Interpreter Needed: ☐Yes ☐No				
Address: Parent/Guardians: Contact Info ☐ Home Phone: ☐ Cell: ☐ Email: Check preferred method of contact ***When applicable, we require a copy of the custodial paperwork denoting guardianship and who makes the primary medical decisions for the client.**	Previous client of Oceanside Community Services? *If so, please indicate services received*: ☐ Medication Management ☐ Outpatient Therapy ☐ Neuropsychological Testing			

Please review the above insurance plans accepted carefully.

Primary Insurance:
Insurance ID Number:
Group Number:

Secondary Insurance:
Secondary Insurance ID Number:
Group Number:

Primary Care Physician ☐ Check if referring person	Name:	Phone: Fax:
Psychiatrist: ☐ Check if referring person	Name:	Phone: Fax:
Counselor/ Therapist: ☐ Check if referring person	Name:	Phone: Fax:
Caseworker/ Case Mgr: ☐ Check if referring person	Name: Agency:	Phone: Fax:
Other Professional: ☐ Check if referring person	Name: Type:	Phone: Fax:
School:	Name: ☐ Homeschooled	District:

Current Diagnoses (*please include medical diagnoses):*	**Current Medications** (*please include all medications including over the counter):*
Current Services	
Reason for Referral	*Please tell us your reason for seeking treatment:*

Thank you for considering Oceanside Community Services!

Do you experience any of the following? Check all that apply	☐ Traumatic brain injury / concussion ☐ Birth Injury ☐ Anxiety ☐ Depression ☐ Anger ☐ Poor social skills / no friends ☐ Medication interactions ☐ Sexual misbehavior ☐ Substance Abuse in pregnancy ☐ Autism characteristics ☐ Moodiness / Emotional dysregulation ☐ Obsessive or compulsive behaviors ☐ Oppositionality / Defiance ☐ Difficulty w/ Attention / Concentration ☐ Psychosis ☐ Other concerns- Describe:
Previous Psychological or Neuropsychological Testing	☐ Yes (Please provide info) Name of provider (*please include if OCS*): ☐ No Date of most recent testing: Reports available: ☐ Yes **(Please provide)** ☐ No ☐ Not Applicable
Have you had a hospitalization, crisis evaluation or residential placement in the past 2 years? **If yes,** please explain and provide dates.	
Have you ever been diagnosed or treated for any of the following:	☐ Substance Use Disorder Circle all that apply: *alcohol, cannabis, opioids, stimulants, other:* _____ ☐ Active ☐ In remission ☐ Eating Disorder Circle all that apply: *Anorexia, Bulimia, Avoidant/restrictive food intake disorder (ARFID), Pica* ☐ Active ☐ In remission

Disclaimer Statement: Please be aware that the providers at OCS are not able to care for people having active trouble with eating disorders (anorexia, bulimia, etc.) or substance use disorders, as these require more specialized care. OCS reserves the right to not continue with treatment if these issues become apparent either during the initial evaluation or through the course of treatment, and will recommend either a higher or alternate level of care to address these problems.

Thank you for considering Oceanside Community Services!