OCEANSIDE
COMMUNITY SERVICES, LLP

22 West Cole Road, Unit 103
Biddeford, ME 04005
P: 207.571.9923 F: 207.571.9927
www.ocsmaine.org

Medication Management 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.

Please note, the providers who staff the medication management department only provide coverage on a part-time basis, four days a week, with no direct after hours or weekend (on call) coverage.

Our providers specialize in the treatment of children, adolescent and young adult. Adult referrals will be accepted on a case-by-case basis. **They 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.

<table>
<tr><td>Date:</td><td colspan="2">Referred by:</td><td></td><td>DOA:</td><td>OCS #:</td></tr>
<tr><td colspan="2">Name:</td><td rowspan="2">D.O.B.:</td><td rowspan="2">Age:</td><td rowspan="2">Gender:</td><td rowspan="2">Grade:</td></tr>
<tr><td colspan="2">Primary Language Spoken:

Interpreter Needed: ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Previous client of Oceanside Community Services?</td><td colspan="4">If so, what department (i.e. psychiatry, neuropsychology, and/or outpatient therapy)? Please be specific.</td></tr>
<tr><td colspan="2">Parent/Guardians:

***When applicable, we require a copy of the custodial paperwork denoting guardianship and who makes the primary medical decisions for the client.**</td><td colspan="4" rowspan="2">Address:</td></tr>
<tr><td colspan="2">Primary Language Spoken:

Interpreter Needed: ☐ Yes ☐ No</td></tr>
</table>

Contact Info ☐ Home Phone: ☐ Cell: ☐ Email: Check preferred method of contact	***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:	**Current Medications:**

Current Services Check all that apply	☐ School IEP/Special Ed ☐ School 504 Accommodations ☐ School Counselor ☐ Tutoring ☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy ☐ Vision Therapy ☐ Naturopathy ☐ HCT ☐ BHP ☐ VRT ☐ MST ☐ Psychotherapy ☐ Behavior Therapy (e.g., ABA) ☐ Group Therapy ☐ Social Skills training ☐ Other- Describe:
Current Status Check all that apply	☐ DHHS Involvement ☐ Foster Care ☐ Adoption Process ☐ JSOP/Probation Supervision ☐ Incarcerated ☐ Residential Treatment
Reason for Referral	Current concerns/ Identified Issues / Duration of problems / Progress in treatment.

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Thank you for considering Oceanside Community Services!

<table>
<tr><td rowspan="3">Developmental History</td><td>Were there any significant developmental difficulties</td><td>Prenatal</td><td>Infancy (birth-2yrs)</td><td>Early Childhood (2-4yrs)</td><td>Late Childhood (5-7yrs)</td><td>Latency (8-12yrs)</td><td>Adolescents (13-17yrs)</td></tr>
<tr><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>No</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Cognitive Concerns
Check all that apply</td><td colspan="7">☐ General Intellectual Abilities
☐ Academic Skills / Learning disabilities
☐ Language / Communication
☐ Sensory Processing
☐ Auditory / Phonological Processing
☐ Reasoning / Problem solving
☐ Executive Processing (sequencing, shifting between tasks, working memory, processing speed, multi-tasking, etc.)
☐ Attention / Concentration
☐ Memory / Learning
☐ Visual Spatial Processing
☐ Motor Functioning
☐ Social Cognition
☐ Judgment / Decision making
☐ Other cognitive concerns
Describe:</td></tr>
<tr><td>Other Concerns
Check all that apply</td><td colspan="7">☐ Traumatic brain injury / concussion
☐ Birth Injury
☐ Anxiety
☐ Depression
☐ Anger
☐ Poor social skills / no friends
☐ Other concerns- Describe:
☐ Substance Abuse in pregnancy
☐ Autism characteristics
☐ Moodiness / Emotional dysregulation
☐ Obsessive or compulsive behaviors
☐ Oppositionality / Defiance
☐ Sexual misbehavior</td></tr>
<tr><td>Previous Psychological or Neuropsychological Testing</td><td colspan="7">☐ Yes (Please provide info)
☐ No
Name of provider:
Date of most recent testing:
Reports available: ☐ Yes (Please provide) ☐ No</td></tr>
<tr><td>Recent hospitalizations or crisis evaluations</td><td colspan="7">Date: Location:
Reports or discharge summary available: ☐ Yes (Please provide) ☐ No</td></tr>
<tr><td>Office Use</td><td colspan="7">☐ Approved ☐ Not within guidelines.
Reason:
Initials: ☐ Insurance Confirmed</td></tr>
</table>

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