Child & Adolescent
Psychiatric Services of Maine
Peter Y. Kang, DO
Board Certified Child and Adolescent Psychiatrist

Referral Form

Date of Referral: _____

REFERRAL SOURCE

Referring Provider Name: _____ Agency: _____

Contact Phone #: _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Social Security #: _____ Sex: ☐ Female ☐ Male ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY PERSON RESPONSIBLE FOR CHARGES:

Name of Guarantor: _____

DOB: _____ SSN: _____

Address of Guarantor _____

Contact phone #: _____ Relation to Patient: _____

Health insurance: _____ Prescription coverage? **Y / N**

Policy #: _____ Group #: _____

Medical History

PRIMARY CARE PROVIDER

Name: _____

Address: _____

Phone #: _____ Fax #: _____

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CLINICAL INFORMATION

Reason for Referral: _____

_____

Current Psychiatric Treatment & History

Current Symptoms: _____

Current Suicidal/Homicidal Thoughts? ☐ No ☐ Yes, details: _____

Does patient currently have an outpatient mental health provider? ☐ No ☐ Yes, details: _____

_____

Current Psychiatric Medications (*name & dose*, attach list if preferred)

_____

_____

_____

Please submit the Referral Form to:

Child & Adolescent Psychiatric Services of Maine
7 Oak Hill Terrace, Suite 218
Scarborough, Maine 04074

OR

Fax to: (207) 303-0023