Sweetser ***Sweetser 50 Moody Street Saco, ME 04072 207-373-3033***

REFERRAL REQUEST FORM

Referent: _____ Phone Number: _____ Date: _____

Facility/Provider: _____

Patient Information:

Male___ Female___ Other _____ DOB: _____ SS#: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ State/Zip Code: _____

Primary Phone: _____ Phone Type: Cell / Home Permission to Text: Y / N

Email: _____ Permission to Email: Y / N

Parent/Guardian: _____ Phone: _____

For Children – What School do they attend: _____

Additional Info:

Race: _____ Ethnicity: _____ Language: _____

Military: Y / N Employed: Y / N Class Member: Y / N Marital Status: _____

Services Requested:

Reason for Referral: _____

Services Requested: _____

Current Diagnosis: _____

Who/Where/When Diagnosis completed: _____

_____

Primary Care Provider:

Physician/NP: _____

Address: _____ State/Zip Code: _____

Phone: _____ Fax: _____

Insurance Information:

Insurance: _____

Insurance ID#: _____ Group #: _____

Insurance Holders Name: _____ DOB: _____
If different from patient

Medicare #:_____ MaineCare #:_____

Please fax back to Sweetser PromiseLine 207-294-4691