PHYSICIAN OFFICE REFERRAL FORM
MEDICAL ELIGIBILITY DETERMINATION

Date of Referral:					
Client Information					
Name of Client:					Birth Date:
MaineCare ID #:		Social Security #:			Medicare #:
Client's Current Location - Where the Assessment will Occur					
Type of Location:	☐ Home	☐ Hospital	☐ Nursing Home	☐ Res Care	☐Other
Street Address:			Town/ZIP:		Telephone:
Contact Name for Facility if applicable:					Facility Contact's Phone:
Is the Client aware of this referral? ☐Yes ☐No					
Does the Client have (check all that apply): Hearing Loss ☐; Cognition Issues ☐;					Behavior Problems ☐
Doctor's Office Information					
Practice Name:					
Name of Primary Care Doctor:					Doctor's Telephone:
Practice Address:					
Name of Person Sending this Referral:					
Type of Assessment Requested (check one)					
☐ #1 - Advisory Assessment	☐ #13 - Nursing Facility	☐ #30 - Assisted Living Facility	☐ #31 - Residential Care Facility/PNMI		
Person to Contact on Behalf of the Client					
Name & Phone of Client's Primary Contact	Name:				Contact's Telephone:
Contact's Address:					
Relationship to Client:					
Does Client have a Legal Guardian? ☐Yes ☐No ☐Unk	☐ same as above	Name:	Telephone:		
Does Client have a Medical POA? ☐Yes ☐No ☐Unk	☐ same as above	Name:	Telephone:		
Does Client have a Financial POA? ☐Yes ☐No ☐Unk	☐ same as above	Name:	Telephone:		
Referral Comment Information					
Referral Comments:					