GTS | GALLANT THERAPY SERVICES

Work Supports Referral Form

NAME: _____

DATE OF BIRTH: _____

PHONE: _____

ADDRESS: _____

_____

Rep Payee: _____

Address: _____

MAINECARE#:_____

Section #: _____

Diagnosis: _____

DX Code: _____

CASE MANAGER: _____

PHONE#:_____

AGENCY: _____

Address: _____

_____

DATE OF REFERRAL: _____

HEALTH/MEDICAL CONCERNS: _____

_____

_____

LIST MEDICATIONS:_____

_____

_____

_____

EDUCATION

HIGH SCHOOL: _____

GED/DIPLOMA: ___YES ___NO
YEAR COMPLETED/GRADUATED: _____
OTHER EDUCATION/CLASSES:

_____
_____
_____
_____

(IF APPLICABLE)
GUARDIAN: _____
PHONE: _____

E-MAIL:_____
ADDRESS: _____

12 Shuman Ave., Suite 16, Augusta, ME 04330, Phone (207) 623-3900 Fax (207) 480-1541
20 East Ave., Unit 34, Lewiston, ME 04240, Phone (207) 509-0282 Fax (207) 716-4002
840 Kennedy Memorial Dr., Oakland, ME 04963, Phone (207) 716-1863 Fax (207) 716-4002

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_____

LEGAL/CRIMINAL HISTORY:

_____

_____

PREVIOUS WORK OR VOLUNTEER EXPERIENCE:

_____

_____

_____

_____

_____

IS THE INDIVIDUAL INVOLVED IN ANY OTHER SERVICES PRESENTLY?

_____

_____

_____

HOW WILL PERSON BE TRANSPORTED TO AND FROM THE PROGRAM?

_____

PLEASE ATTACH THE FOLLOWING (IF AVAILABLE):

_____ PSYCHOLOGICAL REPORTS
_____ MEDICAL INFORMATION

PRIMARY CONTACT PERSON TO SCHEDULE MEETINGS:

NAME: _____
PHONE: _____
E-MAIL:_____

Emergency Contacts:

1. Name: _____

Phone: _____

Address: _____

_____

2. Name: _____

Phone: _____

Address: _____

_____

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