GTS | GALLANT THERAPY SERVICES

12 Shuman Ave. Suite 16 Augusta, Maine 04330 PH: 207-623-3900 FAX: 207-480-1541

Adult Referral Occupational Therapy Evaluation

Client Information

Name: _____ **DOB:** _____ **Age:** _____

Are they their own guardian? **Yes** ☐ **No** ☐

Do they have a payee? **Yes** ☐ **No** ☐

Date of Referral: _____ Address: _____

Residential Facility Name (If applies): _____ House Manager: _____

Home Number:_____ Cell Phone:_____ Fax: _____

Email: _____

Mental Health Diagnosis (if known):_____

_____

Medical Issues (Diagnosis): _____

_____

Current Medications:_____

_____

Allergies:_____

_____

Does the client have SIB (self injurious behaviors)?: Yes ☐ **No** ☐

Brief Explanation: _____

_____

Does the client have aggression/unsafe behavior towards others?: Yes ☐ **No** ☐

Brief Explanation: _____

_____

Contact Requesting Eval Information

Contact requesting eval: _____ Relationship to Client: _____

Agency (If applicable)**:** _____ Phone Number: _____

Email: _____ Fax Number: _____

Address:_____

How did you hear about Gallant Therapy Services? (Check all that apply)

☐ Facebook ☐ Vocational Rehab ☐ Case Manager (what agency?) _____

☐ Doctor Office (what office?) _____ ☐ Friend ☐ Instagram

☐ Other (please share) _____

Reason for client being referred for Occupational Therapy (OT)?

(What are staff/guardian concerns, what would staff/guardians like the client to work on for skills?)

_____

_____

_____

****Please provide us with the contact information needed to schedule the client. If we should reach out to the client directly to schedule please write their name on the line. If the Guardian or Case Manager will be setting up the date and time please put them on the line provided****

Primary Contact for Scheduling:_____

Relationship to Client: _____ **Phone Number:**_____

Fax Number:_____ **Email:**_____

Information on Current Services

(Write agency / provider that provides services on line provided below)

☐ **Community Supports:** _____

☐ **Counseling/Psychiatrist:**_____

☐ **Occupational Therapy:**_____

☐ **Medication Provider:**_____

☐ **Education:** _____

☐ **Residential Facility:** _____

☐ **Vocational Rehab:** _____

☐ **Physical Therapy:**_____

☐ **Speech Therapy:** _____

☐ **Other:** _____

☐ **Primary Care Doctor + Agency:**_____

Primary Care Phone Number: _____

Primary Care Fax Number: _____

Primary Care Address: _____

☐ **Primary Insurance:** _____

MaineCare Identification Number: _____

Please attach copy of MaineCare ID Card when submitting referral packet

IF APPLICABLE

Guardian Information

Guardian Name:_____

Contact Number: _____ **Email:** _____

Address: _____

Relationship to Client: _____

Case Manager Information

Name:_____ **Agency:** _____

Contact Number:_____ **Email:**_____

Address: _____

Agency Fax Number: _____

Representative Payee Information

Name:_____ **Agency:**_____

Contact Number: _____ **Email:** _____

Address: _____

Relationship to Client: _____

Staffing Information

Agency providing staff: _____

Staff Title (type of staff ex: MHRT-1, PSS, DSP etc.): _____

Frequency of Staff (Days a week/hours): _____

Staff Ratio(1:1, 2:1, etc.):_____

Please mail or fax applicable documents upon referral:

⏪ MaineCare Insurance Card
⏪ Person Centered Plan (PCP)
⏪ Psychological Evals
⏪ Vocational Rehab Evals
⏪ Medication List
⏪ Diagnosis (Last doctors appointment, etc.)
⏪ Any Other Pertinent Information

Email to: Alyssa MacDonald, amacdonald@gallanttherapyservices.com (fastest referral method)

Fax to: 480-1541

Mail to: Gallant Therapy Services

12 Shuman Ave. Suite 16 Augusta, ME 04330

Call the office: 207-623-3900