Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Help Me Grow Maine

REFERRAL FORM

Referring Provider: _____ Date: _____

Office Address: _____
Address Town State Zip Code

Phone: _____ Fax: _____ E-Mail: _____

Child's Name: _____Gender: Male☐ Female☐ Unknown☐

DOB: _____ or ☐Prenatal (Expected Due Date): _____

Child's Race: _____ Child's Ethnicity: _____ Child's language:_____

Parent/Caregiver Name: _____

Phone: _____ E-Mail: _____

Address: _____
Address Town State Zip Code

Primary Insurance: _____ Child's Diagnosis (if known): _____

Why are you referring to HMG?_____

What is your Expected outcome:_____

Has a developmental screening tool been completed? ☐ Yes; _____ ☐ No
Name of screening completed

Does child have an active IEP/IFSP ☐Yes ☐No / Is this child connected with CDS? ☐Yes ☐No

Have referrals for the child been completed? If yes, please list service and provider:

_____

_____

_____

Please list **prior** services/supports if any: _____
Client's Parent/Caregiver has consented to referral: ☐ Yes ☐ No

Release on file for referring agency to communicate with Help Me Grow Maine: ☐ Yes ☐ No

Please email or fax referral and release to the following:
Email: Helpmegrow@maine.gov
Fax: 207-624-7994