



Patient self-referred. Please provide needed information.

Attn: GUIDE Program

Date Sent:

Fax Number:

Patient Name:

Date of Birth:

Patient Phone:

Caregiver Name (if applicable):

Caregiver Phone:

Caregiver resides with patient Yes No

Caregiver Email:

Address:

Patient Email:

County of Residence: Androscoggin Cumberland (parts of, Andwell will determine eligibility)
 Franklin Kennebec Lincoln (Dresden only) Oxford Sagadahoc
 Somerset (Anson, Mercer, New Portland, Starks only) York (Cornish, Limington, Parsonsfield only)

Primary Care Provider:

Phone:

Referring Provider:

Phone:

Dementia Diagnosing Provider:

Phone:

Our office identified a patient who may benefit from GUIDE services, whose eligibility is demonstrated by meeting the below GUIDE program criteria.

- The patient has traditional Medicare (A & B) as their primary payer. Medicare Number:
 The patient is not enrolled in Medicare Advantage or another Medicare Health plan, PACE or the hospice benefit.
 The patient does not reside in a long-term skilled nursing home.

Fax this completed form to: Attn: Patient Services Center at 207-307-2668

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Patient Name:

Date of Birth:

The remainder of this form should be completed by a provider:

The patient has one of the below dementia diagnoses (*check all that apply*). Be as specific as possible.

<input type="checkbox"/>	F01.xx	Vascular dementia - ICD 10:
<input type="checkbox"/>	F02.xx	Dementia in other diseases classified elsewhere - ICD 10:
<input type="checkbox"/>	F03.xx	Unspecified dementia - ICD 10:
<input type="checkbox"/>	F10.27	Alcohol dependence with alcohol-induced persisting dementia
<input type="checkbox"/>	F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
<input type="checkbox"/>	F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
<input type="checkbox"/>	F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
<input type="checkbox"/>	F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
<input type="checkbox"/>	F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
<input type="checkbox"/>	F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
<input type="checkbox"/>	F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
<input type="checkbox"/>	G30.0	Alzheimer's disease with early onset
<input type="checkbox"/>	G30.1	Alzheimer's disease with late onset
<input type="checkbox"/>	G30.8	Other Alzheimer's disease
<input type="checkbox"/>	G30.9	Alzheimer's disease, unspecified
<input type="checkbox"/>	G31.1	Senile degeneration of brain, not elsewhere classified
<input type="checkbox"/>	G31.2	Degeneration of nervous system due to alcohol
<input type="checkbox"/>	G31.01	Pick's disease
<input type="checkbox"/>	G31.09	Other frontotemporal neurocognitive disorder
<input type="checkbox"/>	G31.83	Neurocognitive disorder with Lewy bodies

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Please include the following with your patient's referral:

History and physical

Medication list

Consultative note re: the patient's dementia type/diagnosis

Last 2 office visit notes

Discharge summary from any recent hospitalizations or Emergency Department visit

Demographics (including Medicare benefit number and caregiver contact information)

Power of attorney and/or guardianship documentation

Advanced directive and/or POLST

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