***Hansel Union Consulting, PLLC***

***Therapeutic Consult Referral Packet***

Behavioral \_\_ **\_\_\_\_\_\_**Occupation **\_\_\_\_\_\_\_\_\_**  Speech **\_\_\_\_\_\_** Recreation

Please submit the following information when requesting Therapeutic Consultation through Medicaid Waiver.

Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CSP Dates: \_\_\_\_\_\_\_\_\_\_ TO \_\_\_\_\_\_\_\_\_\_\_\_ Quarterly Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CSB:

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential/Home Contact: Phone:

Day Support/Work Contact: Phone:

The following documents must be included:

**\_\_\_\_\_\_\_\_\_** ISP **\_\_\_\_\_\_\_\_\_\_\_\_\_**Residential Behavior Placements - History

**\_\_\_\_\_\_\_\_\_** Psychological Evaluation **\_\_\_\_\_\_\_\_\_\_\_\_\_**TDO Reports and Hospitalizations

**\_\_\_\_\_\_\_\_\_**  Medical Evaluation

**\_\_\_\_\_\_\_\_\_**  LOF/SIS

**\_\_\_\_\_\_\_\_\_**  Provider Choice

Release of Information

Guardian/POA (if applicable)

**Mail or Fax to:**

**Hansel Union Consulting, PLLC**

**640 North Street**

**Portsmouth, VA 23704**

**Phone (757) 967-9926 Fax (757) 673-6320 www.hanselunion.com**