Hansel Union Consulting, PLLC
640 North Street, Portsmouth VA 23704
Phone: 757-967-9926

Therapeutic Consult Referral Packet

__ Behavioral __ Recreation __ Speech __ Occupation __ Physical __ Psychological

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: ____________________

Legal Guardian Contact: __________________________ Phone: ____________________

Doctor's Name: __________________________ Phone: ___________ Fax: ____________

The following documents must be included:

___________ISP

___________Psychological Evaluation

___________Medical Evaluation

___________LOF/SIS

___________Release of Information

___________Residential Behavior Placements - History

___________TDO Reports and Hospitalizations

___________Provider Choice

___________Guardian/POA (if applicable)

___________Insurance Card(s)

Email or FAX to: **Fax (757) 673-6320** **charlie@hanselunion.com**

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, (Client), ____________________________________ D.O.B: ______________________

I authorize (party making disclosure): ____

To release to, or exchange with: Hansel Union Consulting, PLLC

The following information may be used for Therapeutic Consultation Services. I understand that I may revoke this consent at any time except to the extent that those receiving this authorization have already acted in reliance on it. This consent will automatically expire upon the following date, event, or condition:

One year from date signed or upon discharge of service

My signature means that I have read this form or have had it read to me and explained in a language that I can understand, and that I do in fact agree to this release of information.

SIGNATURE: ____________________________________ ______________
(Client) Date

____________________________________ ______________
(Guardian/Authorized Representative) Date

Notice: In the event of Substance Abuse referrals or of disclosure of information that would identify a person as a current or past alcohol or other substance abuser, Federal Regulation (42CFR Part 2), which have the force of law, prohibit re-disclosure of the information without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization is not sufficient for this purpose.

In other cases, disclosure of records generally cannot occur except with the written consent of the client or by court order. However, some disclosures may occur without prior consent in circumstances specified by Federal, State, and local laws and regulations, including the Community Regulation governing the rights of program clients. The confidentiality of this client-clinician relationship is subject to those laws and regulations.