

Hansel Union Consulting, PLLC

640 North Street, Portsmouth VA 23704

Phone: 757-967-9926

Therapeutic Consult Referral Packet

☐ Behavioral ☐ Recreation ☐ Speech ☐ Occupation ☐ Physical

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/VIDES _____ Residential Behavior Placements-History

_____ Psychological Evaluation _____ TDO Reports and Hospitalizations

_____ Medical Evaluation _____ Provider Choice

_____ LOF/SIS _____ Guardian/POA (if applicable)

_____ Release of Information _____ Insurance Card(s)

Authorized Signature for Services: _____

Printed Name: _____

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.