**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 *(please list specific reason(s) for the services requested):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**](mailto:charlie@hanselunion.com)

**Hansel Union Consulting, PLLC**

640 North Street, Portsmouth VA 23704

Phone: 757-967-9926

Fax: 757-673-6320

|  |
| --- |
| **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.