New Patient Referral for the IPSIDD/Independent Program

Please verify submission of the following documents:

- ☐ Referral Face Sheet (see below)
- ☐ Life plan (most recent on file)
- ☐ Front and back of **current** insurance cards, including Medicaid and Medicare
- ☐ Scripts for all applicable therapies
- ☐ Initial Physician MD Order for all applicable therapies
- ☐ Last psychological and psychosocial evaluations (if requesting psychology)
- ☐ All Evaluations and Plan of Care must be approved and signed by the Physician MD requesting all Applicable Therapy Services

We very much appreciate in advance the prompt and thorough completion of this packet. Please complete, scan, and then upload or fax all of the above applicable items. You may also copy and mail these items, but understand this may mean a delay in processing.

Name of Group:	Essential OT, PT, SLP, & Psychology Services, PLLC
Attention:	Idomenee Medy, Director of Clinical Programs
Address:	2703 Milburn Avenue Baldwin, NY 11510
Phone:	917-499-8496
Fax:	804-336-6220
Email:	medy.essential@gmail.com

IPSIDD/Independent Services Referral Face Sheet

Name (Last, First)	
Medicaid #	
Date of Birth	
SSN	
Full address of treatment location Location type (Group/private home, day hab, etc.)	
Treatment location contact's name and relationship	
Contact's email	
Contact's best phone	
Name, email, phone of Care Manager (Specify which CCO)	
Patient medical history Please include all diagnosis codes	
Please check all that apply. For patients referred for psychology services, please describe the reason for referral	
☐ OT – Occupational Therapy	To improve impaired fine motor skills, upper extremity strength, ameliorate cognitive impairments (via ADLs, money management)
☐ PT – Physical Therapy	To increase endurance to gait, ambulation, stair climbing, wheelchair/walker management, upper and lower body strength
☐ ST – Speech Therapy	Ameliorate effects of expressive and receptive language disorders, swallowing disorders, sign language to indicate needs and wants
☐ Psy – Psychotherapy/Counseling	
☐ Psychosocial Evaluation – Logical + Social	Psychological evaluation being requested + Psychosocial evaluation being requested

Consent/Release Statement

I am consenting to receive IPSIDD clinical services from the above Multi-Practitioner Group.I authorize any holder of medical information about me to release to the Group's Claims Administrators any information needed to determine these benefits or the benefits payable for related services.

☐Individual is unable to sign. Responsible part is completing the below on individual's behalf.	
Name of Individual or Representative	
Title/Relationship to Individual	
Signature	
Date of Consent	

Request for Initial Physician's Order (Mandatory OT, SL, PSY, NT & PT)

Patient Name (Last, First):	
DOB:	**Agency/Site:**
Referred to Independent Clinical services: ☐OT	
Referred to Independent Clinical services: ☐PT	
Referred to Independent Clinical services: ☐ST	
Referred to Independent Clinical services: ☐SWLW	
Referred to Independent Clinical services: ☐Psy	
Referred to Independent Clinical services: ☐NT	
Referral for eMod for safety & health of patient ☐	
Referral for DME eMod for health & safety of patient ☐	
Location being requested	
Desired location of service. Check one	☐IRA ☐Day Hab ☐FMC ☐IPSIDD Group's Office ☐Other____ICF_____

I, the undersigned, agree that the above-named individual, residing at the above-named agency and site, would benefit from the selected therapeutic services.

☐EVALUATE AND TREAT AS NEEDED.

Therapist is to provide initial evaluation with treatment plan to be reviewed and approved by Physician MD.

Name of Physician MD:_____

State License Number:_____

Date of Order: _____

Physician's signature:

_____