Spectrum Support Services, LLC
marysearls@spectrumsupportservices.org
804-316-9944
NPI: 1548731987

Behavioral Therapy Consultation Service Referral Form

REFERRING SERVICE COORDINATOR (SC)									
SC Name & CSB					Email				
Best Contact #			Fax #						
FOCUS PERSON INFORMATION									
First & Last Name					Preferred Name				
Medicaid #		Date of Birth				Gender			
Waiver Type	Community Living (CL)			Family & Individual (FIS)					
ISP Date Range	START DATE:				TO	END DATE:			
Quarterly Due Date	Q1		Q2		Q3		Q4		
Address									
Own Decision Maker?	Yes [__]				No [__]				
PARENT/ LEGAL GUARDIAN/ SUBSTITUTE DECISION MAKER INFORMATION									
First & Last Name									
Address									
Best Contact #									
Best Email / Fax #									
Power of Attorney?	Yes -				No -				
Please attach a copy of the following documents with your referral									
SIS		RAT		ISP		VIDES		VIC	

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Please provide the reason for seeking Therapeutic Consultation Service	
• **Challenging or unwanted Behaviors** o Self-Injury (hitting self, head banging, scratching/skin picking) o Property Destruction o Aggression- Physical and/or Verbal o Attention-seeking behaviors o Inappropriate sexual behavior – includes exposing self, lack of social boundaries, illegal porn, harassment, public masturbation, etc. o Offending behavior with/without Law Enforcement involvement o Mood disorder o Anxiety disorder o Post Traumatic Stress Disorder o Substance Usage o Elopement o Suicidal Ideation or Attempts o Emotional Outbursts – use of profanity, refusal of reasonable safety requests o Rectal digging or fecal smearing o Other:	• **Psych Diagnoses and Concerns** o Anxiety o Depression / Major depressive o Obsessive Compulsive Disorder o Visual/Auditory Hallucinations or Psychotic Features o Grief / Loss o Reactive Attachment Disorder o Mood Disorder / Dysregulation o Sexual Disorder o Schizophrenia / Schizoaffective disorder o Bipolar o Crisis Behaviors / History of hospitalization o Substance Use o Other: • **Skill Delays** o Daily Living Skills o Cognitive Skills o Social Skills o Leisure Skills o Receptive Language o Expressive Language o Coping Skills

Please include any additional important information regarding the need for services in the box below. If known, please include the client's availability for sessions and preference for in-person, virtual, or hybrid services:

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Authorization to Release Information			
Focus Person Name		**Medicaid #**	

I, _____, hereby authorize *Spectrum Support Services, LLC* and its affiliated practitioners to release and/or obtain information to/from the following individual or entity regarding my behavioral therapeutic consult, including but not limited to diagnosis, treatment plans, progress reports, and any other medical records that pertain to my behavioral health.

Spectrum Support Services, LLC Therapy Consultation Provider, is allowed to exchange information with the following parties in order to initiate therapeutic consultation services:

1. Service Coordinator(s)/ Case Manager (SC/CM);
2. Providers assigned to ISP;
3. Virginia Waiver Specialists, Inc (Therapy Provider Support);
4. Kids Connected ABA (professional mentorship)

I understand that this information may be shared with other healthcare providers, insurance companies, or third-party payers for the purpose of continuing my care or processing claims.

This authorization shall remain valid for one year from the date of signing or until I revoke it in writing, except to the extent that action has already been taken in reliance on this authorization.

I understand that I have the right to revoke this authorization at any time by submitting a written request to Spectrum Support Services, L.L.C., except to the extent that action has already been taken in reliance on this authorization.

I understand that I have the right to refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

Focus Person Signature		**Date**	
[If patient is a minor or is assigned a legal guardian, the parent or legal guardian must sign below]			
Substitute Decision Maker/ Legal Guardian Name			
Relationship to Focus Person			
Substitute Decision Maker/ Legal Guardian Signature		**Date**	