Patient Referral to Easterseals Rehabilitation Center

Patient: ____

Parent/Guardian (if patient is under 21): ____

Date of birth: ____________________ Phone: _______________ Cell: _______________

Diagnosis and reason for visit: ____

Insurance: ______________________________ Is prior authorization needed? Yes_____ No_____

If prior authorization is needed, please list authorization number: _______________________

Please attach a copy of:

Last Office Note, Demographics Sheet, and Insurance Card.

Is the client aware of this referral? Yes_____ No____

SELECT ONLY THE SERVICES THAT APPLY:

Medical Services
(Kitts NPI: 1750387247; Edinger NPI: 1952519613)

- ☐ Consultation:
  Ellen Kitts, M.D.
  Jason Edinger, D.O.
  Pediatrics/PM&R
- ☐ Jennifer Diserio, CRNP

Rehabilitation Services
(Facility NPI: 1134124647)

- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Speech language therapy

Autism Evaluation
(Facility NPI: 1134124647)

- ☐ Autism Diagnostic Observation Schedule (ADOS-2) *(medical and speech, occupational, and/or physical therapy evaluations, as needed)*

Kendall Behavioral Solutions
(NPI: 1184171175)

- ☐ Applied Behavior Analysis (ABA) consultative therapy *(autism diagnosis required)*
- ☐ Functional Behavioral Assessment (FBA)

Referring Physician (print): ____

Physician NPI: ____

Physician Address: ____

Physician Phone Number: ______________________

I am referring the above patient to Easterseals Rehabilitation Center for evaluation and treatment.

Signature__________________________________ **Date**________________

Physician must sign referral. PCP must obtain prior authorization from insurance, if required.

Easterseals Rehabilitation Center
1305 National Road, Wheeling, WV 26003
Phone: 304-242-1390 | Fax: 304-243-5880

Thank you for entrusting the care of your patient to us.