Mountain Lake Services
Article 16 Clinic
New Enrollment/Referral Form

Name:_____ Date of Birth:_____ Sex:_____

Street Address:_____ City:_____State:_____Zip:_____

Phone:_____ Social Security #:_____

Type of Residence:_____ Qualifying Diagnosis:_____TABS ID:_____

Insurance Information:

Medicaid #:_____ Medicare #:_____

Third party insurance:_____

Company: _____Policy #:_____Group #:_____

Insured Party:_____Relationship:_____

Address:_____

Additional Insurance information:_____

Referral Source:

Name:_____Phone:_____ Email:_____Relationship: _____

Address:_____

Services Requested:

Physical Therapy ☐ Speech & Language ☐ Psychology ☐

Occupational Therapy ☐ Mental Health Counseling ☐ Psychiatry ☐

Is this person currently receiving the requested therapy? Yes / No If Yes, Location:_____

Reason for Referral: (Please describe current needs and concerns.)

_____

_____

Contact Information:

1. Care Manager: _____ Email:_____ Phone:_____

2. Registered Nurse:_____ Email:_____ Phone:_____

3. QIDP:_____Email:_____ Phone:_____

4. Consent Provider:_____ Email:_____ Phone: _____

Address: _____

Mountain Lake Services
Article 16 Clinic
New Enrollment/Referral Form

5. Legal Guardian*_____Email:_____ Phone:_____

Address: _____

*Guardian must be notified and must give consent for the services being provided.

6. Primary Care Physician: _____Phone: _____

Address:_____

Diagnostic & Specialist Reports Attached:

Medical: _____

Psychological: _____

Developmental: _____

Additional Documentation Required at the Time of Referral Processing:

Consent Packet Signed: _____

Annual Physical: _____

Life Plan/IEP: _____

Copy of all Insurance Cards: _____

Signed Script by PCP – Occupational and Physical Therapy: _____

Signature/Title of Person Completing Referral: _____ Date:_____