Patient Referral to Easterseals Rehabilitation Center

Patient: _____

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

Address: _____

Date of birth: _____ Phone: _____ Cell: _____

Diagnosis and reason for visit: _____

Medical history: _____

Insurance: _____ Is prior authorization needed? Yes_____ No_____

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

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

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: _____ Taxonomy: _____

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.

Please attach a copy of current immunizations and remit to:

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.