

THERAPY NEED IDENTIFICATION FORM

This form MUST be used when requesting direct consultation services from a Clinical Services Bureau Therapy Consultant. The following conditions MUST be met to utilize this request form.

- There is no therapist of the discipline requested currently listed on the SFOC form for this county.
- The IDT has determined that therapy services requested are essential to the individual's health, safety, daily functioning, or achievement of ISP Visions and Outcomes.
- The IDT has determined that therapy services requested cannot be provided by or is not appropriate to refer to other Insurance Providers (Use of Dr's order and insurance card).
- The IDT has discussed and determined that therapy services requested cannot be provided by:
 - Another therapy discipline
 - Other IDT members
 - Integrating strategies into the ISP

Name:	DOB:	Case Manager/Agency:
Individual's Address:		Phone:
		Fax:
County of Residence:	Date IDT Completed Form:	E-mail:
Therapy Service Needed: (circle one) PT OT SLP	ISP Budget Dates From: To:	Discussed with Guardian? Yes No Date of Discussion:
Other Services on Budget: (circle all that apply) PT OT SLP BSC	Current Aspiration Risk Status: Low ___ Medium or High ___	Jackson Class Member? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has this therapy service been on the individual's ISP budget within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Check all documents below that have been provided by a previous therapist of the discipline requested:		
<input type="checkbox"/> *Initial Evaluation Report <input type="checkbox"/> *Annual Re-Evaluation Report <input type="checkbox"/> *Therapy Documentation Form <input type="checkbox"/> *CARMP Strategies <input type="checkbox"/> *WDSI <input type="checkbox"/> *AT Inventory <input type="checkbox"/> ISP/Teaching and Support Strategies (TSS).		
Please list the <i>specific outcomes</i> the IDT would like to see from CSB Therapy Consultation Services:		
1-		
2-		
3-		
CM signature:		Date:

Please forward to Felicia Vidro, Therapy Services Coordinator and to the applicable CSB Therapy Consultant through Therap S-Comm.

You MUST Attach:

___ * Most current therapy documents 1 year old or less (Initial or Annual Re-evaluation report, TDF, CARMP, WDSI, and/or AT Inventory).

___ Current ISP ___ Current contact person and contact information for scheduling appointments

CONTACTS:

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