

Center for Assistive Technologies Referral Form

Provider, please choose the appropriate clinic(s) for referral, complete those sections, and sign. Completed referrals can be faxed to 404-350-7356. When faxing this order, please attach the following:

- Medical history and physical chart note from the physician
- Patient face sheet
- Front and back copies of the patient's insurance card

Client Information				
Name:				Date of Birth:
Address:				
City:		State:		ZIP Code:
Home Phone:	Cell Phone:		E-mail:	
PT and/or OT Evalu Diagnosis and/or ICD	ation and Treatment for A			
Select one or more of the Wheelchair Seating and				valuation and Rehabilitation
Access Technology La				
Driving Evaluation an ☐ Driver's License ☐ L	earner's Permit License/P	ermit_#:		Expiration:
Has the client had a seizure				
Current medications that m				
Do you recommend any dri				
If yes, please specify:				
Pressure Ulcer / Pressure	nd Mobility Posture / Adjustment Map Wheelchair	Training 🔲 WI	neelchair Pickup	r Wheelchair
Do you know the Equipmen				
Insurance Type: Medicar	re Medicaid Pr	ivate Insurance:		VR VA
Referral Source				
Provider Name:		Phone:		Fax:
Address:				
City:		State:		ZIP Code:
Provider Signature:			ı	Date:

Appointment will not be scheduled without signature. If you are not contacted by scheduling after 3 business days, please call 404-355-1144.