Shepherd Center

# Center for Assistive Technologies Wheelchair Seating & Mobility Referral Form

Please complete the below sections, including the diagnosis, and sign.
Please attach the most recent medical history and physical or chart note.
***(Not completing the form/providing chart note may delay scheduling)***

## Client Information

Name: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

☐ PT and/or OT Evaluation and Treatment for Assistive Technology Services

**Diagnosis and/or ICD-10 Code (required):** _____

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance: _____

☐ VR ☐ VA

## Wheelchair Seating and Mobility

☐ Manual Wheelchair ☐ Posture / Adjustment ☐ Power Assist Evaluation ☐ Power Wheelchair

☐ Pressure Ulcer / Pressure Map ☐ Wheelchair Training ☐ Wheelchair Pickup

☐ Other: _____

Do you know the wheelchair supplier? ☐ Yes ☐ No If so, please fill out the information below.

Company Name:_____

## Referral Source

Provider Name: _____ Phone: _____

Fax: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Provider Signature: _____ Date: _____

**Appointment will not be scheduled without signature.**

Have this form faxed to 404-350-7356. If you are not contacted by scheduling after **two business days**, please call 404-355-1144.