Shepherd Center

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 Evaluation and Treatment for Assistive Technology Services**
Diagnosis and/or ICD-10 Code: _____

Select one or more of the following services (Access Technology Lab, Driving Evaluation and Rehabilitation, Wheelchair Seating and Mobility) from below and complete that section(s).

Access Technology Lab

☐ Electronic/device access ☐ Specific Requests: _____

Driving Evaluation and Rehabilitation

☐ Driver's License ☐ Learner's Permit License/Permit #:_____ Expiration:_____
Has the client had a seizure or episode within the last year? ☐ Yes ☐ No Date: _____
Current medications that may affect safe driving:_____
Do you recommend any driving restrictions? ☐ Yes ☐ No
If yes, please specify: _____

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 Equipment Supplier? (For seating clinic visits) If so, please indicate below:
Company Name _____
Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance: _____ ☐ VR ☐ VA

Referral Source

Provider Name: _____ Phone: _____ Fax: _____
Address: _____
City:_____ State:_____ ZIP Code:_____

Provider Signature: _____ **Date:** _____

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